PHILADELPHIA REDEVELOPMENT AUTHORITY

SECTION 125 PLAN

PLAN DOCUMENT

This document is provided for informational purposes only. While it is not intended to provide all the details of the Philadelphia Redevelopment Authority Section 125 Plan (the "Plan"), it is intended to help you understand how the Plan works and answer the most frequently asked questions about the Plan. If you still have any questions concerning the terms and conditions of the Plan you may make a request to Human Resources Department who was appointed to handle the day-to-day operation of the Plan by the Philadelphia Redevelopment Authority (the "Employer").

Additional material, such as those that may be provided by an insurance carrier who provide the actual benefits purchased under the Plan, may contain more details concerning the benefits offered under the Plan. While every effort has been made to make certain that the information given to you is consistent between all material, if there is any conflict in this information, the Employer has the responsibility to interpret the conflicting provisions and determine what benefits will be provided. If a dispute arises out of or in connection with the Plan benefits as described in this document, the dispute will be subject to the exclusive jurisdiction of the state and/or federal courts located in Philadelphia, PA.

The Plan is maintained for the exclusive benefit of employees and their eligible dependents

The Plan may not be amended or modified through any oral statement by a representative of the Employer or anyone else working with, or in any way related to, the administration or operation of the Plan. If oral statements are made by individuals that conflict with the actual Plan provisions, the Plan provisions will apply; therefore, you should contact the Human Resources Department or, for the benefits through the Plan, the applicable insurance carrier or claims administrator for Plan information.

Finally the following information is not intended to create and does not create a contract, expressed or implied, or a guarantee of employment for any specific duration. While the Employer intends to continue this Plan indefinitely, the Employer reserves the right, at its sole discretion, to change any of the contents of this document at any time and without notice by action of the Board of Directors. The Employer's right to amend or terminate the Plan includes, but is not limited to, changes in eligibility requirements, premiums, benefits provided and cost-sharing as it relates to any group of employees or dependents. Neither you nor your beneficiaries have a vested or non-forfeitable right to receive benefits under the Plan.

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PLAN PURPOSE

The Philadelphia Redevelopment Authority Section 125 Plan (the "Plan") that is sponsored by Philadelphia Redevelopment Authority (the "Employer") became effective on January 1, 1996 and was restated as of September 1, 2015. The Plan provides benefits as described in this document and the Employee handbook. The Plan enables participating employees to purchase certain benefits as listed on Schedule A on a tax preferred basis or to create individual spending accounts for health and dependent care expenses. The insurance carriers and claims administrators listed on the attached Schedule B provide the actual benefits that can be purchased under the Plan.

In addition, participating employees may elect to waive benefits and receive additional taxable cash.

The following information forms the written plan document as required under the Internal Revenue Code ("IRC" or the "Code").

ELIGIBILITY

Eligibility – Regularly Scheduled Employees

If you are a regular employee of the Employer or a "Participating Employer" (a related employer that has adopted the Plan for its employees, as listed on the attached Schedule D) and you are regularly scheduled to work at least 37.5 hours per week, you are eligible for benefits under the Plan as of your "Entry Date." Your Entry Date is as follows based on the specific benefit.

- Waive Out Option – First day of the month following date of hire as an eligible employee.
- Medical – First day of the month following date of hire as an eligible employee.
- Vision – First day of the month following your date of hire as an eligible employee.
- Spending Accounts – First of the month following 6 months

Finally, for the purpose of the Employer reporting requirements under the Affordable Care Act (ACA), also referred to as health reform, all employees will be monthly measured. This means the Employer will review the hours you actually worked in the previous month to determine your full-time work status for that month.

Eligibility – Other Individuals

Please note that individuals who are classified by the Employer or a Participating Employer as non-employees (e.g., independent contractors) are not eligible to participate in the Plan. The Employer or a Participating Employer also may designate certain other groups of employees (e.g., interns, temporary employees, contract workers, etc.) as not being eligible to participate in the Plan. If you have questions about whether you are eligible to participate in the Plan, you should contact the Plan Administrator.

Eligibility – Dependents

When you become eligible for benefits, your dependents that meet the eligibility criteria described in the applicable insurance carriers' and/or claims administrators' booklet(s) may also become covered for certain benefits as indicated on the attached Schedule A. Your dependents include your domestic partner only if they meet the qualifications of and register for Life Partnership through the Philadelphia Commission on Human Relations (PCHR).

Please note that you may be required to submit documentation of your relationship to any individual that you enroll for benefits under the Plan. The Plan also retains the right to perform eligibility audits on individuals covered for benefits.

NOTE: Although the underlying benefits offered for purchase under the Plan permit domestic partner to be covered for benefits offered for purchase under the Plan such individuals are generally ineligible to purchase the benefits on a pre-tax basis (See "**IMPORTANT INFORMATION ON PLAN ELIGIBILITY**").

IMPORTANT INFORMATION ON PLAN ELIGIBILITY

1. If you cover an individual who **does not meet** the following criteria, the IRS requires that you may be subject to additional taxable income based on the fair market value of the coverage (See Schedule E for additional information.)

    - Your legal spouse;
    - Your tax dependent under the Code Section 152; or
    - For benefits related to healthcare, your dependent under Code Section 105(b) or your child who is under age 27 as of the end of the tax year (December 31).

    The fair market value would be reduced by any contribution you paid on a **post-tax** basis for such individuals. However, if your contributions for a non-tax dependent individual are paid on a pre-tax basis, the entire fair market value of the coverage would become imputed income to you with no reduction for the pre-tax contribution amount.

    NOTE: The above information relates to the federal tax code; state and local tax codes may differ and may result in additional taxes.

2. In addition to being subject to additional taxation described above, if you cover an individual who is not otherwise eligible for Plan benefits, the following may also apply.

    - To the extent permitted by law, claims incurred by an ineligible dependent under the Plan may be denied.
    - You may be subject to any disciplinary action as described in the Employer's employment policies and procedures.

If you have any questions concerning who is an eligible plan participant, please contact the Human Resources Department.

RESCISSION OF COVERAGE

The Plan retains the right to rescind (i.e. retroactively terminate) coverage if it is determined that fraud or intentional misrepresentation was used to obtain or continue the coverage. For example, we retain the right to rescind coverage for a dependent that is not eligible for coverage under the plan's terms. In addition, coverage can be rescinded if you fail to timely pay the required employee contribution amount.

- If rescission of coverage is due to fraud or intentional misrepresentation, you will have a 30-day appeal period. If your appeal is not successful, your coverage will be retroactively terminated to the later of the following dates:
    - The date that the coverage was first obtained based on fraud or intentional misrepresentation; or
    - If the coverage is provided under an insurance contract, the date permitted under the terms of the applicable insurance contract.

- If rescission is due to your non-payment of contributions or premiums, coverage will be retroactively terminated to the later of the following dates:
  - The beginning date of the coverage period for which a payment was not received timely; or
  - If the coverage is provided under an insurance contract, the date permitted under the terms of the applicable insurance contract.

NOTE: As indicated above (see "**Important Information on Plan Eligibility**"), if coverage is rescinded, you may be responsible for any claims incurred after the date of rescission. This includes, but is not limited to, liability for benefits already paid by the plan or carrier during the period following rescission.

ENROLLMENT

You must select which contributory benefits you would like to purchase through the Plan. Your decision must be made during the annual enrollment period that takes place **before** the beginning of each benefit year begins or, for new employees, within the 30-day period that is prior to the date you first satisfy the Plan's eligibility requirements described under **"ELIGIBILITY**". The benefit year for each Plan benefit is as follows.

- Medical – Benefit year is August 1 to July 31
- Vision - Benefit year is August 1 to July 31
- Waive Out Option - Benefit year is August 1 to July 31
- Health Care and Dependent Care Spending Accounts – January 1 to December 31

During each annual enrollment period, you will be provided with the opportunity to change the contributory benefits that you previously elected. If you are already participating in the Plan and you fail to make an election for the upcoming Plan Year (that is, you fail to complete and submit an election form within the time periods established by the Plan Administrator), then you will be treated as having elected (1) to continue your prior year's elections with the exception of any spending account elections and (2) not to establish spending accounts under the Plan. Additionally, by enrolling in a plan that requires contributions, you are authorizing the appropriate deductions to be made from your paycheck.

For benefits provided by the Employer or a Participating Employer that do not require employee contributions, you automatically will be covered for these benefits upon completion of the required waiting period and, if applicable, after submitting any required enrollment forms. Except as provided below, once you make (or fail to make) an election under the Plan and the Plan Year has begun, you may not modify, alter, amend, or revoke your election until the next annual enrollment period.

When Coverage Begins

Coverage begins as follows, provided you complete and submit the necessary enrollment forms by the date indicated:

- *For newly eligible employees and their eligible dependents,* coverage begins the first day of the month following your date of eligibility.
- *For annual enrollment,* coverage begins as follows.
  - Waive Out Option - August 1st
  - Vision – August 1
  - Medical – August 1
  - Waive Out Option - August 1st
  - Health Care and Dependent Care Spending Accounts – January 1

- *For mid-year plan election changes as a result of birth or adoption,* the change is effective on the date of the event or the loss of other coverage if you notify the Human Resources Department and submit the election no later than 30 days after this event.
- *For mid-year plan election changes as a result of marriage,* the change is effective the earlier of the following dates:
  - The date of marriage if you provide the election change to the Human Resources Department **prior to the date of marriage**; or
  - The date that is the first day of the month following the date you notify the Human Resources Department after the marriage if you submit the change of election request to the Human Resources Department no later than **30 days after the date of marriage**.
- *For mid-year election changes due to a change in eligibility under Medicaid,* the change is effective as of the first day of the month following the date you notify the Human Resources Department and the request is made no later than 60 days after the event.;
- *For mid-year election changes due to a change in eligibility under a state Child Health Insurance Program,* the change is effective as of the first day of the month following the date you notify the Human Resources Department and the request is made no later than 60 days after the event. Please note that for CHIP eligibility, you, the employee will not be permitted to drop your group health coverage;
- *For mid-year plan election changes due to a status change (other than changes as a result of marriage, birth or adoption) as outlined below,* the change is effective as of the first day of the month following the date you notify the Human Resources Department of the event and the election change is requested no later than 30 days after the event. However, if the mid-year plan election change is due to a court order adding a dependent to your existing health coverage, the change will be effective as soon as administratively possible.

Mid-Year Plan Election Changes Due to Status Events

Please keep in mind that once made, your choice to receive benefits under the Plan generally must remain in effect for the entire Plan Year. However, under the following special circumstances (referred to as "Status Events"), you may be able to change your selected benefits during the Plan Year.

A Status Event for an employee or a dependent must affect the individual's eligibility for the Plan's benefits. Additionally, any requested change in the affected benefit must be consistent with the occurrence of the underlying Status Event and supporting documentation must be provided with your request for a mid-year election change within the time frame noted below.

The request for an election change must be submitted to the Human Resources Department. Upon receiving notification of the change in status, the Human Resources Department will send you any required forms to complete and sign. Your coverage change will be effective on the first day of the month **after** you provide timely notice as described to the Human Resources Department. However, if the requested change is due to the birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event, again subject to timely notice of the event.

Qualified status events that may permit a mid-plan year election change include the following:

- ***Legal Marital Status***: Your marriage, divorce[1], annulment, or the death of your spouse;

[1] Legally separated spouses continue to be eligible for Plan benefits until the divorce is finalized; however, if another employer's plan does not continue coverage for legally separated spouses and there is a loss of coverage for either you or eligible dependents, you may request a benefit election change.

- ***Number of Dependents***: The birth, adoption, placement for adoption, or death of a dependent;
- ***Employment Status***: The termination or commencement of the employment of you or your spouse or dependent;
- ***Work Schedule***: The reduction or increase in hours of employment or other changes in employment category of you or your spouse or dependent, including a switch between part-time and full-time, a strike or lockout, or commencement of or return from an unpaid leave of absence, including a leave of absence under the Family and Medical Leave Act ("FMLA");
- ***Change in Dependent Status***: Any event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance as provided in the health plan under which you receive coverage;
- ***Residence or Worksite***: A change in the place of residence or worksite of you or your spouse or dependent;
- ***Change of coverage under another employer's plan***: A change is made under another employer plan (including a plan of the same employer or of another employer) or an open enrollment occurs for the employee, spouse, or dependent;
- ***HIPAA Special Enrollment Rights***: A change due to the requirements of HIPAA, see also "**Special Enrollment Rights for Medical Coverage**" below; and
- ***COBRA Eligibility***: A covered individual becomes eligible for COBRA or a state mandated continuation of health coverage benefit.

The following changes are also Status Events, but these Status Events generally ***only affect the medical benefit (includes prescription drug coverage) and healthcare spending account*** and would not entitle you to make a mid-year election change for any other coverage options:

- ***Entitlement to Medicare:*** A covered individual becomes entitled to or loses eligibility for Medicare;
- ***Entitlement to Medicaid:*** A covered individual becomes entitled to Medicaid for other than premium assistance benefits;
- ***Loss of coverage eligibility for Medicaid or under a state Children's Health Insurance Program (CHIP[1]):*** A plan eligible employee or dependent loses coverage under Medicaid or CHIP see also "**Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)**"; and
- ***Judicial Order:*** A change is required by a Qualified Medical Child Support Order ("QMCSO"), see also "**Qualified Medical Child Support Orders**" below, or other judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in custody.

The following changes are also Status Events, but these Status Events *do not apply to a healthcare spending account* and would not entitle you to make a mid-year change in your healthcare spending account election:

- ***Automatic Changes in Your Elections:*** If the costs of certain benefits under the Plan increase or decrease during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically modify your elections to reflect this increase or decrease in costs. These automatic increases/decreases generally will occur in situations where there are small periodic changes in the costs of benefits that occur during the middle of a Plan Year (e.g., an insurance carrier makes a cost-of-living adjustment to its coverage option during the middle of a Plan Year);
- ***Significant Increase in Cost***: A *significant* increase in the cost of a coverage option may allow you to increase your contribution amount, revoke your election and elect similar coverage under another coverage option, or drop coverage if no similar coverage option is available. (Please note that under a dependent care spending account, the cost change rule only applies to cost changes required by a dependent care provider who is not a relative of the employee.);

[1] Entitlement to CHIP does not permit a covered plan participant to drop medical coverage under the Plan.

- ***Significant Decrease in Cost:*** A *significant* decrease in the cost of a coverage option may allow you to revoke your existing election and elect coverage under such option;
- ***Significant Curtailment of Coverage Option:*** A *significant* curtailment of a coverage option that does not constitute a loss of coverage may allow you to revoke your election and elect similar coverage under another coverage option. If the significant curtailment of coverage does constitute a loss of coverage, you also may be allowed to drop coverage if no similar coverage is available;
- ***Addition or Improvement of Coverage Option:*** If a new coverage option is added, or if coverage under an existing option is *significantly* improved, you may be permitted to revoke your existing election and elect the new or improved coverage option; and
- ***Enrollment under a qualified health plan offered by a state health insurance exchange*** **due to either**
  - your becoming eligible for a special enrollment period (SEP) to obtain coverage under a qualified health plan[1] offered by a state health insurance exchange, and you have enrolled or will enroll in the plan that is effective no later than the day immediately following the date you terminate medical benefits under the Plan; or
  - your obtaining coverage under a qualified health plan during the open enrollment period for the exchange

Finally, with the exception of certain changes in eligibility status under Medicaid or CHIP, mid-year plan election changes must be requested no later than **30 days** following the date of the Status Event that is the basis for the change. However, changes due to either of the following must be requested no later than **60 days** following the date of such events.

- Entitlement to premium assistance under Medicaid; or
- Loss of coverage eligibility for Medicaid or CHIP.

Again, as previously noted, if the change request is not made within this time frame, the change may not be made until the next annual enrollment period.

Waiver of Benefits for Dependents

If you previously elected to waive coverage for a dependent, you will be eligible to apply for coverage for that dependent during the next annual enrollment period or, in some circumstances, during a "special enrollment" period as described below under "**Special Enrollment Rights for Medical Coverage**." If you waive coverage for yourself, coverage will also be waived for your dependents. In no event will coverage be in force for your dependents if you have not enrolled in the Plan to receive similar coverage.

Special Enrollment Rights for Medical Coverage

Under certain circumstances, eligible employees who waived coverage for themselves and/or for their dependents may elect to enroll in the Plan without having to wait for the next annual enrollment period. These special rights are provided under the Plan pursuant to HIPAA. HIPAA provides for a special enrollment period under certain circumstances, such as the following two instances:

- ***Loss of Other Coverage:*** If an employee declines coverage for himself and/or his dependents when initially eligible because of coverage under another group health plan or insurance arrangement, and such other coverage terminates, the eligible employee and/or his dependents may elect to enroll in the Plan effective as of the first day of the month after the Human Resources Department receives the enrollment request and "certificate of coverage" from the other health plan; provided, that it is submitted no later than the end of the 30-day period following the of the loss of such other coverage.

- ***New Dependents:*** If an employee declines coverage when initially eligible and subsequently acquires a new dependent through marriage, birth, adoption, or placement for adoption of a child, the employee may elect to enroll the employee, the employee's uncovered spouse (if applicable), and the employee's new dependent(s); provided that the enrollment application is submitted to the Human Resources Department no later than the end of the 30-day period following of such event with appropriate documentation reflecting this change. Coverage will be effective as of the date of the birth, adoption, or placement for adoption, or as of the first day of the month after enrolling due to a marriage, as applicable.

The booklets prepared by the insurance carriers and claims administrators will contain a more detailed description of these Special Enrollment Rights and HIPAA's rules.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272

If you are eligible for this benefit, one of the following procedures will apply. Please see Human Resources to determine which is applicable in your situation:

1. You will be required to pay the full applicable employee contribution amount and then you will be reimbursed by the state for the cost of your child's coverage**, or**
2. Your contribution amount will be reduced by the amount payable by the state and the Employer will collect the premium assistance amount from the state.

Automatic Medical Coverage for 31 Days for a Newborn Child or a Newly Adopted Newborn Child

If you have a child or adopt a child while you are receiving medical coverage under the Plan, your new child will automatically receive medical coverage from the date of birth/adoption for a period of 31 days. If you do not notify the Human Resources Department that you have a new child and/or if you do not apply for medical coverage for the child before the end of this 31-day period, medical coverage for your new child will terminate at the end of the 31-day period.

If you are not already receiving coverage for dependents, and if you are required to contribute toward the cost of coverage, you must apply for medical coverage (and pay any required contribution) within 31 days of having

your new child in order to continue the child's coverage beyond that date. If you are already receiving coverage for dependents, you must still notify the Human Resources Department of your new child so that his/her claims can be processed. Also, if the addition of this new child changes your Plan election, i.e. "Single" to "Family," your contribution amount may be increased accordingly. If you fail to apply for medical coverage (or pay the required contribution) within the 31-day period, benefits will be payable only for covered expenses incurred by the child while coverage was in force. If you fail to timely enroll your new child during the 31-day period, coverage for your new child will cease at the end of the 31-day period and you will have to wait until the next annual enrollment period to enroll your child under the Plan.

Qualified Medical Child Support Orders

Generally, your Plan benefits may not be assigned or alienated. However, an exception applies in the case of a "qualified medical child support order" ("QMCSO"). Basically, a QMCSO is a court-ordered judgment, decree, order, or property settlement agreement in connection with state domestic relations law which either creates or extends the rights of an "alternate recipient" to participate in a group health plan, including this Plan, or enforces certain laws related to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order must satisfy certain specific conditions to be qualified. You will be notified by the Plan Administrator if a medical support order that applies to you is received and the Plan's procedures for determining whether the medical child support order is qualified. You may obtain a copy of these procedures, without charge, by contacting the Plan Administrator.

Except for a QMCSO, your rights and benefits under the Plan generally cannot be assigned, sold, transferred or pledged by you or reached by your creditors or anyone else.

Rehired Employees

If you terminate employment for reasons other than a layoff and are rehired you may resume your participation in the Plan after you again satisfy the eligibility requirements described above.

If you are laid off and then return to work, you may resume your participation in the Plan on the date you return to work.

Contributions and Benefits during a Non-FMLA Leave

Unless otherwise communicated to you or noted below, your benefits that require a contribution will cease if you stop making contributions at any time during the Plan Year. Unless you experience a mid-year status event change, special enrollment right or cease contributions due to leave under the federal Family and Medical Leave Act ("FMLA"), you will not be able to reinstate your benefits on a pre-tax basis until the beginning of the next Plan Year.

Contributions and Benefits during an FMLA Leave

As noted above, if you take leave of absence that is approved under FMLA, you may elect to continue your benefits during the period of your FMLA leave or you may elect to discontinue your benefits. If you elect to continue your benefits while on leave, your contributions will be paid as follows.

- For periods of paid leave, contributions will be deducted from your salary as before you were on FMLA leave.

- For periods of unpaid leave, you must submit your required contributions by the first day of the month.

If you elect to discontinue benefits while on FMLA leave, you generally will be permitted to resume your benefits and to resume making contributions on a pre-tax basis. However, any claims incurred during periods when you discontinued benefits will not be eligible for reimbursement.

A more detailed description of FMLA leaves can be found in the section entitled **"FAMILY AND MEDICAL LEAVE"** below.

EXCLUSIONS AND LIMITATIONS

The benefits offered under the Plan are described below. However, these benefits may be limited under certain circumstances. Benefits may be limited based on the type of service provided, amounts paid on an annual basis or length of benefit periods. Additionally, some services are excluded for coverage. Please refer to the appropriate insurance carriers', claims administrators', or Employer's information for a complete description of a particular benefit's exclusions or limitations. It is important to note that a benefit plan's provisions may also vary in accordance with state requirements.

SCHEDULE OF PLAN BENEFITS

Benefits You Can Purchase on a Pre-Tax Basis

In addition to any Employer-provided benefits, you may elect to receive other benefits and pay for them on a pre-tax basis. The advantage of paying for a benefit on a pre-tax basis is that you will not pay federal income taxes and, in most states, no state or local income taxes. The end result is that you will have a higher take-home pay than if you purchased the same coverage on an after-tax basis. However, as noted above, you may only change your pre-tax elections during annual enrollment unless you have a qualifying status event that is described under the section entitled "**Mid-Year Plan Election Changes Due to Status Events.**"

The benefits that you may purchase on a pre-tax basis under the Plan are as follows:

- medical coverage;
- vision coverage;
- health care spending account see "**SPENDING ACCOUNTS**";
- dependent care spending account see "**SPENDING ACCOUNTS**".

The exact plan options available to you and any required contributions will be communicated to you when you are first eligible for the Plan and during each annual enrollment period. Please remember that each benefit under the Plan has separate rules governing benefits and plan administration. These rules are set forth in the insurance carriers' and claims administrators' booklets. To the extent that you have not received them, you can request copies of these booklets by contacting the Plan Administrator or the insurance carriers directly.

Waive-Out Cash Option

If you elect to waive coverage for medical for yourself and any eligible dependents, you will receive additional cash which is subject to any applicable taxes. However, such amounts do not increase any other benefits based on salary. The amount you may receive for waiving this coverage will be communicated to you when you are first eligible for benefits and during each enrollment period.

Please remember that if you waive coverage, you may not become enrolled in the medical plan until the earlier of the next August 1 or the date you have a qualified life event.

Limitations on Contributions

The maximum contribution amount that you can make under this Plan is an amount equal to the total cost of electing the most expensive plan options available to you.

Nondiscrimination

It is important to note that it is not intended for the Plan to discriminate in favor of highly compensated individuals or key employees as to eligibility to participate, contributions, and benefits in accordance with Code Section 125. In order to comply with these nondiscrimination requirements, the Plan Administrator may exclude certain highly compensated individuals or key employees from participation in the Plan, or limit the contributions made by certain highly compensated participants or key employees, without the consent of the employees.

SPENDING ACCOUNTS

As noted in the above "**SCHEDULE OF BENEFITS**", you may also elect to make pre-tax contributions to a spending account(s). There are two types of spending accounts available to you: a healthcare spending account and a dependent care spending account. You can then use these spending accounts to pay for certain healthcare and dependent care expenses on a pre-tax basis.

Please remember that as noted above, the Plan Administrator may be required to limit or exclude the participation of certain highly compensated individuals or key employees, without their consent.

How Spending Accounts Work

The two spending accounts are for separate categories of expenses – one for healthcare and the other for dependent care expenses. You will make an election to determine how much (if any) will be contributed to your spending account(s) through periodic payroll deductions. The maximum amount that you may contribute to each type of spending account during any given year is described in the attached Schedule C. The amounts that accumulate in your spending account(s) may be used to reimburse you for certain qualifying healthcare and dependent care expenses that you incur during the Plan Year.

To receive reimbursement from your spending account(s), you must complete a claim form and submit it (along with copies of your receipts) to the designated claims administrator listed on Schedule B by the Employer. If applicable, in addition to a paper "claim" you will be offered the ability to use a debit card for healthcare expenses. However, please keep your receipts for expenses paid by through the debit card as the claims administrator may require substantiation of such expenses. If you fail to provide the required substantiation within the required time frame, your use of the debit card will be frozen until either the requested documentation has been received and approved or you repay the amount in question.

If a claim for reimbursement from your healthcare spending account is approved, you will be reimbursed the full amount of your eligible expenses up to the remaining balance of the amount you have elected to contribute for the entire Plan Year (regardless of whether such contributions actually have been made at the time your claim is submitted).

For dependent care expenses, you will only be able to make claims for reimbursement up to the amount you actually have contributed to your dependent care spending account at the time your claim is submitted.

Claims will be paid as soon as administratively possible, but not less frequently as on a monthly basis, provided that all necessary documentation has been submitted.

After the designated claims administrator reviews the claim, you will be informed of the amount to be reimbursed. If you believe that the claim has have been reimbursed incorrectly, you may submit a claims appeal under the claims and appeals procedure established by the claims administrator.

Eligible Expenses Payable from Your Healthcare Spending Account

Expenses that are eligible to be paid from your healthcare spending account include expenses such as deductibles and copayments, uninsured medical and dental expenses, vision care, hearing care and certain other medically necessary over-the-counter expenses. Generally, the expenses covered must be "medically necessary," or, for over-the-counter drugs, include a written prescription by a licensed medical provider to qualify. Covered expenses for this type of spending account *do not include* premiums paid for other health plan coverage (including plans maintained by the employer of your spouse or dependents) or expenses for non-reconstructive cosmetic surgery.

For purpose of the healthcare spending account, expenses must be incurred by qualifying dependents who are individuals who meet the definition under Code 105(b) (See Schedule E for details.)

Eligible Expenses Payable from Your Dependent Care Spending Account

Eligible expenses that may be paid from your dependent care spending account must be expenses for dependent care for your qualifying dependents and must be expenses that are incurred to enable you (if single) and your spouse (if married) to work. For this purpose, qualifying dependents are those individuals who meet the definition of a qualifying dependent under Code Section 21 (See Schedule E for details.) If you have any questions regarding dependent eligibility, you should contact the Human Resources Department.

Examples of eligible dependent care expenses include payments to child-care centers, nursery schools, and schools for qualifying dependent children. Eligible expenses also include payment for summer **day** camps, after-school care, and elderly care. Care within your home by a relative (for whom you do not take a standard tax exemption; provided, that the relative is not a child under 19 or a spouse or a non-relative, as long as such a person is reporting payments as income), also may be eligible.

Please be aware that educational expenses to attend kindergarten or a higher grade and overnight camp expenses **are not eligible** dependent care expenses.

Please keep in mind that you may be able to take a federal tax credit for eligible dependent care expenses up to $3,000 (for one dependent) or $6,000 (for more than one dependent). The credit can equal 35% of expenses, reduced by one percentage point (but not to drop below 20%) for each $2,000 (or fraction) by which your adjusted gross income exceeds $15,000. Any amounts deferred to a dependent care spending account will reduce, dollar-for-dollar, the maximum allowable expense under the tax credit. You should consult your personal tax adviser if you think you may be eligible for this tax credit.

Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for-dollar the federal tax you have to pay, but it is calculated a little differently from the child care credit described above. The credit is available to individuals with a qualifying child who is under age 19 (or under age 24 if a student) or is totally and permanently disabled. An additional credit may be available to individuals with a child under the age of one. The credit does not depend on the amount of money that you pay in child care expenses. This earned income credit has no effect on the amount that you can contribute to a dependent care spending account for such expenses. Additionally, the use of a dependent care spending account may result in a reduction in your taxable income and this reduction could qualify you for the earned income credit.

Other Facts to Consider Regarding Spending Accounts

Although spending accounts provide you with an opportunity to pay certain expenses on a pre-tax basis, the IRS has placed some restrictions on using spending accounts:

- ***Limited Ability to Change Contribution Elections:*** Contribution elections for your spending accounts generally must remain in effect for the entire Plan Year unless you have a Status Event as described above.
- ***Use it or Lose it Feature to Spending Accounts:*** With the exceptions noted below, all spending have a "use it or lose it" feature such that any excess amounts remaining in your spending account(s) after you have submitted all reimbursable claims for the Plan Year will be forfeited to the Employer. Any excess amounts in your spending account(s) cannot be combined, carried over into the next Plan Year, or converted to cash.

  Exception 1: For health care spending accounts only, you will be permitted to carry over to the next Plan Year a balance of up to **$500** any account balances over this amount will be forfeited. This amount will be added to amount you elect for the subsequent Plan Year. Additionally, this amount DOES NOT reduce the annual maximum contribution listed on the attached Schedule C.

  Exception 2: Under the Heroes Earnings Assistance and Relief Tax Act of 2008 (HEART Act), you may be able to receive the balance in your healthcare spending account (this exception does not apply to a dependent care spending account) as cash if you meet all of the following requirements.

  - You are a reservist;
  - You are called into active duty for a period of more than six months; and
  - You provide a copy of your orders to the Employer.

  The cash disbursement of your balance in your healthcare spending account will be subject to applicable taxes.

  So, if you choose to open a spending account, you should exercise care in estimating your reimbursable expenses for the upcoming Plan Year.

- ***Periodic Statements and Submission of Claims:*** When you elect to contribute to a spending account, you will be provided with instructions on how to file a claim with any supporting information. You will receive statements periodically to remind you how much money is left in your spending account(s). This money must be used for expenses incurred before the end of the Plan Year or it will be forfeited. You may continue to submit claims incurred before the earlier of the end of the plan year or the date you end your contributions for up to **90 days** following the earlier of the end of a Plan Year or the date you stopped making contributions to your spending account(s).

FAMILY AND MEDICAL LEAVE

Under FMLA, you may be eligible to take leave for reasons listed below with certain assurances of job security and continuation of existing health coverage while on such leave.

With the exception of leave taken to care for a seriously ill or injured Servicemember, under the federal Family and Medical Leave Act of 1993 ("FMLA"), you may take up to a maximum of 12 weeks of unpaid leave during a 12-month period for a reason listed below with certain assurances of job security and health coverage during this leave. For leave for the care of a seriously ill or injured Servicemember, you may take up to a maximum of 26 weeks in a single 12-month period. The maximum amount of leave available is reduced by FMLA leave used for any reason during the prior 12-month period.

Definition and Terms

For this section of the Plan, the following definitions and terms apply.

"*Continuing treatment by a healthcare provider"* means any one or more of the following;

1. the employee or family member is treated two or more times for the injury or illness, either by, under the supervision of, or due to a referral by, a healthcare provider;
2. the employee or family member is treated for the injury or illness by a health care provider on at least one occasion that results in a regimen of continuing treatment under the supervision of a healthcare provider; or
3. the employee or family member is under the continuing supervision of, but not necessarily being actively treated by, a health care provider due to a serious long-term or chronic condition or disability which cannot be cured (e.g. Alzheimer's disease, severe strokes, terminal cancer).

"*Covered Active duty*" means —

1. in the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country; and
2. in the case of a member of a reserve component of the Armed Forces (members of the U.S. National Guard and Reserves), duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

"*Covered Servicemember or Servicemember*" means-

1. a current member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or
2. a Covered Veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of 5 years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

"Covered Veteran" means an individual who was a member of the Armed Forces (including a member of the National Guard or Reserves), and was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran.

"Next of kin" means the "nearest blood relative" of a covered Servicemember.

"Parent" means the biological parent of an employee or an individual who stood *in loco parentis* to an employee when the employee was a son or daughter. This includes an individual who assumed "day-to-day" responsibility for a child.

"*Qualifying Exigency*" applies to any of the following activities due to or following a spouse's, a child's, or a parent's call to active duty or active duty status by the Reserves or National Guard (does not apply to state service):

1. short-notice deployment activities;
2. military events and related activities;
3. childcare and school activities;
4. financial and legal arrangements;

5. counseling activities;
6. rest and recuperation activities;
7. post-deployment activities;
8. parental care; and/or
9. additional activities.

"*Serious health condition*" is an illness, injury, impairment or physical or mental condition that involves:

1. any period of incapacity or treatment in connection with or consequent to inpatient care (e.g. an overnight stay) in a hospital, hospice or residential medical care facility;
2. any period of incapacity requiring absence from work, school, or other regular daily activities , of more than three calendar days which also involves "continuing treatment by a healthcare provider" (as defined above);
3. continuing treatment by a health care provider for a chronic serious health condition or a long-term condition that is incurable or so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days;
4. any period of incapacity due to pregnancy or prenatal care; or
5. any absence to receive multiple treatments for restorative surgery or medical intervention such as chemotherapy for cancer or dialysis for kidney disease.

"Serious injury or illness" means –

1. in the case of a current member of the Armed Forces (including a member of the National Guard or Reserves), an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member's office, grade, rank, or rating; and
2. in the case of a covered veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during a period described in paragraph (15)(B), a qualifying (as defined by the Secretary of Labor) injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member's active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran and is:

    i. A continuation of a serious injury or illness that was incurred or aggravated when the covered veteran was a member of the Armed Forces and rendered the servicemember unable to perform the duties of the servicemember's office, grade, rank, or rating; or
    ii. A physical or mental condition for which the covered veteran has received a U.S. Department of Veterans Affairs Service-Related Disability Rating (VASRD) of 50 percent or greater, and such VASRD rating is based, in whole or in part, on the condition precipitating the need for military caregiver leave; or
    iii. A physical or mental condition that substantially impairs the covered veteran's ability to secure or follow a substantially gainful occupation by reason of a disability or disabilities related to military service, or would do so absent treatment; or
    iv. An injury, including a psychological injury, on the basis of which the covered veteran has been enrolled in the Department of Veterans Affairs Program of Comprehensive Assistance for Family Caregivers.

"Son or daughter" means a biological, adoptive, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis, who, with the exception of a seriously ill or injured Servicemember, is (1) under 18 years of age, or (2) 18 years or older and incapable of self-care because of a mental or physical disability. For the care of a seriously ill or injured Servicemember, there is no age requirement.

"*Spouse*" means a husband or wife as defined or recognized under state law for purposes of marriage, including common law marriage in states where it is recognized.

Eligibility for Leave

To be eligible for FMLA benefits, you must: (1) have at least twelve (12) months of service; and (2) have worked at least 1,250 hours during the 12-month period preceding the start of the leave.

Reasons for FMLA Leave

FMLA leave is available for the following reasons:

- the birth, adoption, or placement of a child for adoption or foster care;
- to care for an immediate family member (spouse, child, or parent) with a "serious health condition" (as defined below);
- for your own "serious health condition", which renders you unable to perform the essential functions of your position;
- for a Qualifying Exigency due to your spouse, child, or parent being on active duty or called to active duty status in support of a contingency operation as a member of the National Guard or Reserves; or
- to care for a seriously ill or injured Servicemember.

Amount of FMLA Leave

With the exception of leave taken to care for a seriously ill or injured Servicemember, under the federal Family and Medical Leave Act of 1993 ("FMLA"), you may take up to a maximum of 12 weeks of unpaid leave during a 12-month period for a reason listed above. For leave to care for a seriously ill or injured Servicemember, you may take up to a maximum of 26 weeks in a single 12-month period.

Not including leave for the care of a seriously ill or injured Servicemember, the available amount of FMLA leave in any 12-month period is measured on a rolling basis backwards from the date the leave in question begins. For care of a seriously ill or injured Servicemember, the leave year is the 12-month period beginning on the start date of leave for such purpose.

Each time you take FMLA leave, the remaining leave entitlement would be the balance of the 12 weeks or, if leave involves leave for the care of a seriously ill Servicemember, 26 weeks that had not been used during the immediate preceding 12 months. If you and your spouse are employed by the Employer and are both otherwise eligible for FMLA leave, the two of you are entitled to a combined total of up to 12 or, if applicable 26 weeks of FMLA leave for the birth, adoption, placement for adoption or foster care of a child, or care of an ill or injured Servicemember. FMLA leave must be taken consecutively except that taking intermittent leave or working on a reduced schedule is permitted when medically necessary due to your own serious health condition or that of your spouse, child or parent or to care for a Servicemember.

Notice and Certification Requirements

When the need for leave is known in advance, an application for leave should be submitted in writing to the Human Resources Department at least **30 days** before you want the leave to begin. When the need arises unexpectedly and unless there are unusual circumstances, you must report your need for leave in accordance with the Employer's report of absence procedures. If you request leave due to your own or a family member's serious health condition, you will be required to provide, within **15 days** of the request, medical certification from a healthcare provider on an Employer-provided form. Recertification of a serious health condition during

leave and an update regarding your intent to return to work is required every 30 days in most cases. The Human Resources Department has the forms and related information or will know who you need to contact to get them.

Failure to comply with certification and documentation requirements may result in a delay, a denial or revocation of FMLA leave.

Integration with Other Leave

Unless prohibited by state law, FMLA leave runs concurrently with any one or more of the following types of leave: occasional absence, short-term disability, salary continuation, vacation and personal days. All accrued vacation, personal leave and sick days must be used as part of the FMLA leave. You will then be entitled to an additional period of leave on an unpaid basis for a combined total of 12 or, if applicable, 26 weeks of leave. Even absent a request for FMLA leave, the Employer may designate an absence as FMLA leave and count it toward your statutory entitlement of 12 or, if applicable 26 weeks if the Employer determines that the leave qualifies or may qualify as FMLA leave.

In addition, if you are also eligible for leave under state law, such leave will run concurrently with FMLA leave unless prohibited by state law. You can receive additional information about such state laws by contacting the Human Resources Department.

Benefits

While on FMLA leave, your health and other benefit coverage will continue under the same terms as if you were working, and you continue to be responsible for the same portion of your health premiums and for payment(s) for other Employer benefit coverage as you paid before taking the leave. During unpaid FMLA leave, you must arrange for personal payment in accordance with the provisions of the applicable plans. If a required premium is not received within **30 days** of the due date, the coverage may be dropped for the remainder of the leave. If you do not retain health benefits during an FMLA leave, coverage may be reinstated upon return from the leave on the same terms that were in effect prior to the leave, subject to any adjustments made for similarly situated employees, without any qualifying period, physical examination or exclusion for pre-existing conditions. However, any claims **will not be reimbursed** if incurred during any period during which you did not pay your required contribution and coverage was dropped for non-payment.

Except as required by COBRA, the Employer's obligation to maintain health benefits ceases upon any of the following:

- you inform the Employer of your intent not to return from leave;
- you elect not to continue health coverage during the leave;
- your required premium payment is delinquent by more than 30 days, or
- you fail to return after an FMLA leave is exhausted.

There will be no loss of seniority rights or any benefits accrued prior to the date on which leave is commenced. During an FMLA leave of absence, personal leave, sick time, holidays, and vacation time will not accrue unless otherwise determined by the Employer on a uniform and nondiscriminatory basis.

Return to Work

With limited exceptions for certain "key employees," as defined by law, employees who timely return from FMLA leave, upon or prior to exhaustion of such leave, will be returned to their original or equivalent position, with equivalent pay, benefits and other employment terms. You may be required to provide a fitness-for-duty medical certification prior to returning to work if leave was taken for your own serious health condition. Such

certification may also be required by the Employer whenever there is a question about fitness for duty. The Employer may require a second medical opinion, by a physician of its choice and at its own expense. Given conflicting opinions, the Employer may require and pay for a third medical opinion from a jointly selected physician.

A voluntary election not to return to work will result in termination of health coverage and an obligation to repay any health premiums paid by the Employer on your behalf during any period of unpaid leave. Repayment may not be required if the failure to return is due to a continuation, recurrence or onset of a serious health condition or other circumstances beyond the employee's control. As with any leave, a failure to return upon expiration of an FMLA leave may be treated as a voluntary resignation.

BENEFIT TERMINATION

Your benefits will terminate in accordance with the schedule included in the table below. In addition to this schedule, your benefits will terminate on the occurrence of the earliest of the following events:

- The termination of the Plan or the amendment of the Plan to eliminate one or more benefits previously provided under the Plan;
- Your or your covered dependent's
  - inability to meet the eligibility requirements to participate in the Plan as set forth in this summary or the insurance carriers' booklets or other materials; and
  - any payroll contributions or premiums have been adjusted accordingly;
- Your revocation of your election to participate in the Plan and receive benefits under the Plan; or
- Your failure to make any contributions required to receive benefits under the Plan. (Note: In order to continue any contributory benefit during any type of leave, you will be required to continue your contributions. If you are no longer receiving a paycheck, you must remit contributions to the Plan by personal check on an after-tax basis.)

Event	**Medical and Vision**	**Flexible Spending Accounts**	**Waive Out Cash**
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*
You are voluntarily or involuntarily terminated from employment	End of the month following termination date, unless COBRA is elected	Healthcare (**HFSA**): Date of termination, unless COBRA is required and elected Dependent Care (**DFSA**): Date of termination	Date of termination
You take an approved leave for your own disability (leave will run concurrently with Family and Medical Leave Act) – This also applies to disability under Workers' Compensation	End of the month following the earliest of the date that you terminate your contribution, the date you fail to return to work when your approved leave expires or the date that is six months after leave began, unless COBRA is elected	**HFSA** – The earlier of the date you terminate your contribution or the date your approved FMLA leave ends, unless COBRA is required and elected. **DFSA** -Please note that while you may continue to contribute to your dependent care spending account, you generally do not incur eligible expenses if you are not at work.	Date leave begins

Event	Medical and Vision	Flexible Spending Accounts	Waive Out Cash
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*
You take an approved leave under Family and Medical Leave Act for non-employee disability reasons	End of the month following the earlier of the date that you terminate your contribution or the date you fail to return to work when your approved leave expires, unless COBRA is elected	**HFSA** - Date that is the earlier of the date that you terminate your contribution or the date you fail to return to work when your approved leave expires, unless COBRA is required and elected **DFSA** - Please note that while you may continue to contribute to your dependent care spending account, you generally do not incur eligible expenses if you are not at work.	Date leave begins.
You take an approved personal leave (Leave of Absence (LOA))	End of the month following the earlier of the date that you terminate your contribution or the date that is six months from the date your leave began, unless you elect COBRA	**HFSA** - On the date your leave begins, unless COBRA is required and elected. **DFSA** - Please note that while you may continue to contribute to your dependent care spending account, you generally do not incur eligible expenses if you are not at work.	Date leave begins
Your Death	End of the month following date of death unless your dependents elect COBRA	**HFSA** - On the date of your death, unless COBRA is required and elected by your dependents. **DFSA** – On the date of your death.	On the date of your death
You take Military Leave	Benefits continue for 31 days, and thereafter, benefits continue in accordance with USERRA (Uniform Services Employment and Reemployment Act)	**HFSA** - On the date your leave begins, unless COBRA is required and elected. **DFSA** – On the date your leave begins.	Date military leave begins
You retire	Coverage will end at the end of the month following the date of your retirement, unless you elect COBRA or unless post-retirement coverage is available from the Employer and you are eligible for and elect such coverage	**HFSA** - On the date your retirement begins, unless COBRA is required and elected. **DFSA** – On the date your retirement begins.	Date of retirement

Event	Medical and Vision	Flexible Spending Accounts	Waive Out Cash
	Coverage Terminates at the/on the	*Coverage Terminates at the/on the*	*Coverage Terminates at the/on the*
Your child is no longer a dependent under the Plan	Coverage will end at the end of the month following the date that your child is no longer a dependent, unless your child elects COBRA.	**HFSA** - Coverage will end at the end of the tax year in which a child is no longer an eligible dependent under Section 105 of the tax code, unless COBRA is required and elected. **DFSA** – Coverage will end at the end of the month in which the dependent no longer is an eligible dependent under Section 129 of the tax code. See Schedule E for information on the tax code.	N/A
You are divorced	Coverage will end at the end of the month following the date of the divorce, unless your spouse elects COBRA.	**HFSA** - Coverage will end on the date of the divorce, unless COBRA is required and elected. **DFSA** – N/A	N/A

COBRA

Continuation of Coverage under COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”), you and your eligible dependent(s) may be eligible to continue health coverage if your or your eligible dependent(s) coverage ends because of certain “qualifying events.” The following information outlines the continuation of coverage available under COBRA. This information may change if the COBRA provisions are changed by federal law that applies to this Plan. In this instance, the Plan’s COBRA procedures will automatically be revised to be in compliance with the new legislation. Additionally, if applicable to you, you will receive additional information regarding the changes to COBRA.

COBRA requires most employers who sponsor group healthcare plans to provide a temporary extension of coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer’s plan. Under COBRA, you (or your dependents) will generally be permitted to continue the same coverage that you (or your dependents) had prior to the event that would otherwise cause the loss of coverage. This temporary extension of benefits is commonly called “continuation coverage.” Below is a summary of who is eligible for continuation coverage under COBRA, when, and for how long. In addition, please refer to the “**COBRA AND MEDICARE**” section of the document that follows this “**COBRA**” section.

These individuals	May continue coverage if it is lost due to…	For up to…
Employee	• reduction in hours of employment • termination of employee’s employment for any reason other than gross misconduct • failure to return from a leave of absence under the Family and Medical Leave Act of 1993	• 18 months[1] • 18 months[1] • 18 months[1]
Covered spouse of an employee	• reduction in employee’s hours of employment • termination of employee’s employment for any reason other than gross misconduct • employee’s failure to return from a leave of absence under the Family and Medical Leave Act of 1993 • death of employee • divorce • employee becomes entitled to Medicare and elects Medicare as primary provider	• 18 months[1] • 18 months[1] • 18 months[1] • 36 months • 36 months • 36 months[2][3]
Covered dependent children of an employee	• reduction in employee’s hours of employment • termination of employee’s employment for any reason other than gross misconduct • employee’s failure to return from a leave of absence under the Family and Medical Leave Act of 1993 • death of employee • employee’s divorce • employee becomes entitled to Medicare and elects Medicare as primary provider • loss of dependent status under existing medical coverage	• 18 months[1] • 18 months[1] • 18 months[1] • 36 months • 36 months • 36 months[2][3] • 36 months

(1) The 18-month continuation coverage period may be extended to 29 months for all covered persons if any covered person eligible for continuation coverage is disabled under the Social Security laws at any time no later than the first 60 days of continuation coverage. To qualify for this extension, the Company must be notified within 60 days of the determination that a covered person is disabled under the Social Security laws and within the initial 18-month continuation period. ***A disabled employee is considered to have terminated employment on the date his or her salary continuation benefits from the Company end, if the employee does not return to work.***

(2) The entitlement to Medicare is ONLY a COBRA event if the entitlement does or would have caused the loss of health coverage for active employees.

(3) If an employee becomes entitled to Medicare while actively-at-work and then terminates employment, dependents will be eligible to receive COBRA coverage for the greater of the 18-month period beginning on the date of termination or the 36-month period beginning on the date the employee became entitled to Medicare.

The 18, 29, or 36 months of continuation coverage begins on the later of the date of the event that causes loss of coverage or the date coverage is actually lost.

Individuals who are eligible for COBRA coverage are called “qualified beneficiaries.” The events that entitle them to coverage are called “qualifying events.” Generally, to be a qualified beneficiary, you must have health coverage under the Plan on the day before a qualifying event occurs; however, a child born to, adopted by, or

placed for adoption with the covered employee during the continuation coverage period is also a "qualified beneficiary."

Loss of Coverage – When a qualifying event occurs, you and the Employer have certain responsibilities. **If the qualifying event is divorce or loss of dependent status, you or your eligible dependent must notify the Human Resources Department in writing within 60 days of the qualifying event**. The Employer will know if the event is death, termination of employment, reduction in hours, failure to return from a leave of absence under the Family and Medical Leave Act of 1993, entitlement to Medicare benefits[1], or the commencement of a bankruptcy proceeding.

When the Human Resources Department is notified or learns of a qualifying event, the Human Resources Department will send you or your eligible dependent(s) a written explanation of the right to elect continuation coverage.

You then have 60 days from the later of the date of this explanation or the date on which your existing coverage would end to notify the Human Resources Department of your election. If you or an eligible dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

COBRA Election – Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one eligible dependent may make an election that covers some or all of the others. Unless amended by law, the following will apply if you elect to continue coverage:

- You must pay a total premium equal to the group rate plus a 2% administration charge monthly (or such higher charge as may be permitted by law).[2] The total premium includes the Employer's contribution and any contribution an active participant is required to make under the Plan.

- The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for months after your election will regularly be due on the first day of the month (the "due date") and must be paid within 31 days (the "grace period") of the date due. Premium rates may change periodically for all qualified beneficiaries.

  Your coverage will continue for as long as you make payment before the end of the grace period. However, if you pay after the due date but during the grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) once payment is made. This means that any claim that you submit for benefits before payment is made will be denied until payment is made. If you fail to make payment by the end of the grace period, you will lose all rights to continuation of coverage under the Plan.

The coverage provided will be identical to the coverage provided similarly-situated employees or dependents. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

- In considering whether to elect continuation coverage, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another

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[1] The entitlement to Medicare is ONLY a COBRA qualifying event if the entitlement does or would have caused the loss of health coverage as an active plan participant.

[2] If you or your covered dependent is eligible for the additional 11 months of coverage because of disability, the premium for the additional 11 months is increased to 150% of the group rate. This increased premium may also apply through the 36th month if a second qualifying event later extends the continuation period to 36 months.

group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment rights at the end of continuation coverage if you elect continuation coverage for the maximum time period available to you.

Other Options Available to You When You Lose Group Health Coverage -

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Benefits for Eligible Dependents – Unless otherwise specified in the election, any election of continuation coverage made by you or your spouse or former spouse will be considered to be an election of continuation coverage for any eligible dependent who would also lose coverage by reason of the qualifying event. If you elect continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of benefits until the next open enrollment period. At that time, they may change their coverage if they wish.

However, if you decide not to continue your coverage at all, each eligible dependent may make an independent benefit selection.

Changes to Continuation Coverage – Qualified beneficiaries have the same opportunities to change coverage as active employees during the annual open enrollment period. During open enrollment, you may elect different coverage or add or delete dependents, in the same manner as an active employee.

When COBRA Benefits End – Generally, continuation coverage runs for 18, 29, or 36 months, depending on the qualifying event, as described in the chart above; however, unless otherwise prescribed by law, COBRA benefits will end immediately if:

- The required COBRA premium is not paid in a timely manner;
- The person whose coverage is being continued becomes entitled to Medicare benefits (this does not apply if you are a retired employee or family member entitled to purchase continuation coverage due to commencement of a bankruptcy proceeding by the employer);
- In the case of the person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the person is no longer disabled under the Social Security laws[1];
- **For healthcare spending accounts only** – If continuation of your health care spending account is subject to COBRA, this coverage can only be continued until the end of the plan year in which the COBRA was elected; or
- The Employer no longer maintains a group health plan covering any employee.

Two Qualifying Events – An 18-month or 29-month period of continuation coverage may be extended if another qualifying event (other than a bankruptcy proceeding) occurs during that time. However, no one may extend coverage for more than 36 months. The 36-month period is counted from the first event. For example, if

[1] A qualified beneficiary is responsible for notifying the Employer within 30 days of the date of a final determination that he or she is no longer disabled under the Social Security laws.

your employment ends and you get divorced during the 18-month continuation period for which you have elected continuation coverage for you and your dependents, your dependents may extend coverage for up to 36 months from the date your employment ended. Please note, if the former Employee becomes entitled to Medicare, and unless the entitlement to Medicare is a terminating event for active participants, the remaining qualified beneficiaries may continue COBRA for the remainder of the 18-month period.

Other available continuation coverage – Under the Plan, you may have the right when your group health coverage ends to enroll in an individual health insurance policy with your same insurance carrier, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right instead of electing COBRA, or you may exercise this right after you have received the maximum COBRA continuation coverage that is available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

COBRA AND MEDICARE

As noted in the above sections on **"COBRA"** and "**MEDICARE AND ELIGIBILITY**", your Medicare status may affect your COBRA and/or Medicare coverage. The following is a summary of this information.

- If you or your spouse or your dependent child is enrolled in Medicare when a COBRA qualifying event occurs, you are still eligible to elect COBRA.

- If you or your spouse or your dependent child is not enrolled in Medicare when a COBRA qualifying event occurs, you are eligible to elect COBRA but COBRA will terminate if Medicare is elected after electing COBRA.

- If Medicare is elected and COBRA is terminated, COBRA is still available to any remaining qualified beneficiaries in your family.

- If you terminate employment within 18 months after becoming enrolled in Medicare, your spouse and dependent child become entitled to COBRA coverage for a period of 36 months from the date you enrolled in Medicare.

- When you are covered by Medicare AND are still not actively employed, Medicare is the primary payer of benefits and COBRA coverage is the secondary payer.

- COBRA coverage **is not** considered medical coverage based on active employment; therefore, Medicare-eligible qualified beneficiaries should understand that late premium penalties may apply if the individual does not enroll in Medicare within the time frame required upon becoming entitled to Medicare. Also there may be a delay in when Medicare coverage begins.

- COBRA is not available to your covered dependents if, while you are actively employed, you voluntarily waive group medical coverage and elect only Medicare coverage.

For additional information on Medicare benefits, enrollment rights, and premium penalties, please contact Medicare or go to the Medicare website at www.**medicare**.gov.

PLAN ADMINISTRATION

The Employer has overall responsibility for the administration of the Plan. From time to time, the Employer may delegate to one or more of its members the right to act on its behalf in any one or more matters connected with the administration of the Plan. The Employer is responsible for the operation and administration of the Plan, including matters relating to interpretation of Plan provisions, claims for benefits and appeals of denied claims, implementation of Plan administration procedures, and compliance with IRS rules and regulations. Benefits under this Plan will be paid only if the Employer (or its delegate) decides in its discretion that the applicant is entitled to them. In many instances, the Employer has delegated the authority to administer the Plan to the insurance carriers and claims administrators providing benefits and services under the Plan.

The decisions of the Employer (or its delegate) in all matters relating to the Plan (including but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

AMENDMENT OR TERMINATION OF THE PLAN

Plan Amendment – The Employer will have the right to amend this Plan at any time, including the right to add or delete one or more benefits and provide additional benefits, coverages or options under this Plan.

Successor Employer – In the event of the sale, dissolution, merger, consolidation or reorganization of the Employer, provision may be made by which this Plan will be continued by the successor to the Employer. In that event, such successor will be substituted for the Employer under this Plan if the Employer consents. The substitution of the successor will constitute an assumption of this Plan's liabilities by the successor and the successor will have all of the powers, duties and responsibilities of the Employer to which it succeeds under this Plan.

Merger or Consolidation – In the event of any merger or consolidation of this Plan with any other cafeteria plan maintained or to be established for the benefit of all or some of the Participants of this Plan, the merger or consolidation will occur only if:

- Resolutions of the Employer's Board of Directors, and the governing body of any new or successor employer of the affected Participants, authorize such merger or consolidation; and
- Such other cafeteria plan satisfies the requirements of Section 125 of the Code.

Plan Termination – The Employer intends to continue this Plan indefinitely, but the Employer in its sole discretion reserves the right to terminate the Plan at any time. Upon complete or partial termination of this Plan, the rights provided in this document with respect to a Participant or other individual affected by such complete or partial termination will be terminated.

However, in the event this Plan is completely or partially terminated, any expenses incurred by an affected Participant up to the date of complete or partial termination will be reimbursed in accordance with the terms of this Plan. Any elected contribution amounts deducted from an affected Participant's compensation will be available to the Participant for any expenses incurred prior to the date of complete or partial termination until the last day of the Plan Year in which such complete or partial termination occurs. To the extent any such contributions remain after the last day of the Plan Year in which such complete or partial termination occurs, such amounts will be forfeited by the Participant in accordance with the "Use it or Lose it" provision under the Spending Account Section of this document and retained by the Employer.

GENERAL PLAN INFORMATION

The following information is general information about the Plan.

Name of Plan

Philadelphia Redevelopment Authority Section 125 Plan

Participants

The Plan provides benefits for all employees of Philadelphia Redevelopment Authority who meet the eligibility requirements described herein.

Plan Sponsor

Philadelphia Redevelopment Authority
1234 Market Street, 16th Floor
Philadelphia, PA 19107

Type of Plan, Plan Definition, and Plan Funding

The Plan also provides covered individuals with the opportunity to purchase benefits on a pre-tax basis through a Code Section 125.

Fiscal Year

August 1 – July 31

IMPORTANT NOTICES

1. SUMMARY INFORMATION ABOUT YOUR HEALTH INFORMATION PLAN PRIVACY AND SECURITY

The Privacy Rules and Security Rules that are part of the Health Insurance Portability and Accountability Act (HIPAA), require that employees who elect to participate in a group health plan option receive a written notice of how an individual's health information may or may not be used without the individual's authorization and the security precautions used to protect any electronically transmitted health information.

Because the health benefits offered under the Plan include both fully insured plan options and a self-insured plan option(s) (this refers to the health care spending account), each plan option is required to provide you with a separate notice that indicates your rights and protections under the applicable health plan.

General Information Concerning Your Privacy and Security Rights under an Insured Health Plan

As indicated above, your insurance carrier will provide you with a notice that details their privacy and security policies and procedures but the following will give you some basic information.

Under the healthcare insurance carrier's privacy procedures, the Plan will generally only receive summary health information from the carrier. Summary health information includes, but is not limited to, information used to evaluate plan rates, pay monthly premiums, establish plan eligibility, evaluate the terms and conditions of the insurance contract, or information used for such activities as plan amendments, plan modifications, or plan terminations. In addition, enrollment information such as names, addresses, dates of birth, and dependent status, will be shared with the healthcare insurance carrier. The Security Rules relate to when this information is transmitted electronically.

If a Participant requests assistance with a claim issue(s), the Plan may be required to obtain written authorization from the Participant before any specific health claim information can be obtained from the healthcare insurance carrier. Plan Participants have the right to revoke such authorizations at any time.

Please note that the requirements of the Privacy Rules and the Security Rules do not apply to health information related to disability benefits, workers' compensation benefits, life benefits, or employment-related information (i.e. sick notes, drug tests, etc.).

Summary of the Privacy and Security Notice Related to Your Individual Medical Information under a Self-Insured Plan Option

Covered entities under the Privacy Rules and Security Rules which includes any self-insured group health plan options (again this refers to the health care spending accounts) are required to maintain the privacy of "protected health information," which includes any identifiable information that we obtain from you or others that relates to your health, your health care, or payment for your health care under a medical plan option. The Security Rules apply when this information is transmitted electronically.

The following is a summary of the Privacy and Security Notice that follows this Summary.

Uses of Protected Health Information

- The group health plan can use or disclose your protected health information for purposes of health care payment, treatment, and health care operations.

- The group health plan may disclose your protected health information to your family or friends or any other individual **identified by you in writing.**

- The group health plan will only disclose the protected health information directly relevant to their involvement in your care or payment.

- Except for certain situations, the group health plan will not use or disclose your protected health information for any other purpose unless you provide authorization. You have the right to revoke that authorization at any time.

Your Rights

- You have the right to request restrictions on the uses and disclosures of protected health information, but the group health plan is not required to agree to your request.

- You have the right to request to receive communications of protected health information by alternative means or at alternative locations.

- With some exceptions detailed in the full notice provided by the Plan, you have the right to inspect and copy the protected health information contained in a covered entity's records.

- You may request a correction to your protected health information, but the group health plan may deny your request.

- You have the right to receive an accounting of disclosures of protected health information made by the group health plan.

- Please remember this is only a summary of the information that is generally applicable to protected health information created under a health plan option offered by the Plan.

Filing a Complaint

If you believe that your privacy rights have been violated, you should immediately contact our Privacy Officer which is the Human Resources Department at Philadelphia Redevelopment Authority.

Contact Person

If you have any questions or would like further information about this notice, please contact our Privacy Officer.

2. DETAILED NOTICE OF PRIVACY AND SECURITY PRACTICES OF THE PHILADELPHIA REDEVELOPMENT AUTHORITY SECTION 125 PLAN

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Philadelphia Redevelopment Authority Section 125 Plan _(the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The Notice is effective September 23, 2013.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information (PHI)". Generally, PHI is health information, including demographic information, collected from you, or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, from which it is possible to individually identify you and that relates to the following. Please note that wherever the term health information is used in this Notice, it will mean PHI.

(1) Your past, present, or future physical or mental health or condition;

(2) The provision of health care to you; or

(3) The past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact:

Human Resources Department
Philadelphia Redevelopment Authority
1234 Market Street, 16th Floor
Philadelphia, PA 19107

THE PLAN'S COMMITMENT TO PRIVACY

The Plan is committed to protecting the privacy of your PHI. The Plan also pledges to provide you with certain rights related to your health information.

By this Notice, the Plan informs you that it has the following legal obligations as required by the federal health privacy provisions contained in HIPAA, the HITECH Act, and the related regulations ("federal health privacy law" and "security rules"):

- To maintain the privacy of your health information;

- To provide you with this Notice of its legal duties and privacy and security practices with respect to your health information; and
- To abide by the terms of this Notice.

This Notice also informs you how the Plan uses and discloses your PHI and explains the rights that you have with regard to your health information maintained by the Plan. For purposes of this Notice, "you" and "yours" refers to participants and dependents that are eligible for benefits described under the Plan.

INFORMATION SUBJECT TO THIS NOTICE

The Plan collects certain health information about you to help provide health benefits to you and your eligible dependents, as well as to fulfill legal requirements. The Plan collects this information, which identifies you, from applications and other forms that you complete, through conversations you may have with the Plan's administrative staff and health care providers, and from reports and data provided to the Plan by health care service providers or other employee benefit plans. The health information the Plan has about you includes, among other things, your name, address, phone number, birth date, social security number, employment information, and medical and health claims information. This is the information that is subject to the privacy practices described in this Notice. Additionally, if this information is transmitted electronically, it is subject the Security Rules under HIPAA.

SUMMARY OF THE PLAN'S PRIVACY AND SECURITY PRACTICES

The Plan's Uses and Disclosures of Your Health Information

The Plan uses your health information to determine your eligibility for benefits, to process and pay your health benefits claims, and to administer its operations. In some cases, your health information may only be disclosed with your written authorization, while in other instances, your authorization is not required. For example, the Plan may disclose your health information, without your authorization, to insurers, third party administrators, and health care providers for treatment, payment and health care operations purposes. The Plan also may disclose your health information, without your authorization, to third parties that assist the Plan in its operations, to government and law enforcement agencies, to your family members in limited instances, and to certain other persons. The details of the Plan's uses and disclosures of your health information are described below.

Your Rights Related to Your Health Information

The federal health privacy law provides you with access to your health information and with certain rights related to your health information. Specifically, you have the right to:

- Inspect and/or copy your health information;
- Request to receive your health information through confidential communications;
- Request that your health information be amended;
- Request an accounting of certain disclosures of your health information;
- Request certain restrictions related to the use and disclosure of your health information;
- File a complaint with the Plan or the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated; and
- Receive a paper copy of this Notice.

These rights and how you may exercise them are detailed below.

Contact Information

If you have any questions or concerns about the Plan's privacy practices, or about this Notice, or you wish to obtain additional information about the Plan's privacy or security practices, contact the individual or department noted on page 1 of this Notice.

DETAILED NOTICE OF THE PLAN'S PRIVACY AND SECURITY PRACTICES USES AND DISCLOSURES

Except as described in this section, as provided for by federal, state or local law, or as you have otherwise authorized, the Plan only uses and discloses your health information for the administration of the Plan and for processing claims.

Uses and Disclosures for Payment, and Health Care Operations

1. **For Payment.** The Plan may use and disclose your PHI to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

2. **For Health Care Operations.** The Plan may use or disclose your health information, without your authorization, to enable it to operate efficiently and in the best interests of its participants. For example, the Plan may use or disclose your health information to conduct audits or actuarial studies, or for fraud and abuse detection.

Uses and Disclosures to Business Associates

The Plan discloses your health information, without your authorization, to its business associates, which are third parties that assist the Plan in its operations, for treatment, payment and health care operations. For example, the Plan may share your health information with a business associate for the purpose of obtaining accounting or consulting services or legal advice. The Plan enters into agreements with its business associates to ensure that the privacy of your health information is protected from unauthorized disclosure and, to the extent electronic protected health information is shared with its business associates, such business associates will comply with the HIPAA Security Rule to the extent required by law.

Uses and Disclosures to the Plan Sponsor

The Plan may disclose health and eligibility information, without your authorization, to the Plan Sponsor for plan administration purposes such as eligibility determinations, enrollment and disenrollment activities, and Plan amendments or termination. The Plan Sponsor has certified to the Plan that it will protect the privacy of your health information and that it has amended the plan documents to reflect its obligation to protect the privacy and security of your health information.

Other Uses and Disclosures That May Be Made Without Your Authorization

The federal health privacy law provides for specific uses or disclosures of your health information that the Plan may make without your authorization, which are described below.

1. **Required by Law.** The Plan may use and disclose health information about you as required by federal, state, or local law.

2. **Additional Legal Reasons.** The Plan may disclose your health information for the following purposes:

   - For judicial and administrative proceedings pursuant to court or administrative order, legal process and authority;
   - To report information related to victims of abuse, neglect, or domestic violence; or
   - To assist law enforcement officials in their law enforcement duties.

3. **Health and Safety.** Your health information may be disclosed to avert a threat to the health or safety of you, any other person, or the public, pursuant to applicable law. Your health information also may be disclosed for public health activities, such as preventing or controlling disease or disability, and meeting the reporting and tracking requirements of governmental agencies such as the Food and Drug Administration.

4. **Government Functions.** Your health information may be disclosed to the government for specialized government functions, such as intelligence, national security activities, and protection of public officials. Your health information also may be disclosed to health oversight agencies that monitor the health care system for audits, investigations, licensure, and other oversight activities.

5. **Active Members of the Military and Veterans.** Your health information may be used or disclosed to comply with laws related to military service or veterans' affairs.

6. **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws related to workers' compensation and similar programs.

7. **Emergency Situations.** Your health information may be used or disclosed to a family member or other person responsible for care in the event of an emergency, or to a disaster relief entity in the event of a disaster.

8. **Others Involved In Your Care.** In limited instances, your health information may be used or disclosed to a family member, close personal friend, or others who the Plan has verified are involved in your care or payment for your care. For example, if you are seriously injured and unable to discuss your case with the Plan, the Plan may so disclose your health information. Also, upon request, the Plan may advise a family member or close personal friend about your general condition, location (such as in the hospital) or death. If you do not want this information to be shared, you may request that these disclosures be restricted as outlined later in this Notice.

9. **Personal Representatives.** Your health information may be disclosed to people you have authorized or people who have the right to act on your behalf. Examples of personal representatives are parents for minors, and those who have the Power of Attorney for adults.

10. **Research.** Under certain circumstances, the Plan may use or disclose your health information for research purposes, as long as the procedures required by law to protect the privacy of the research data are followed.

11. **Organ and Tissue Donation.** If you are an organ donor, your health information may be used or disclosed to an organ donor, eye, or procurement organization to facilitate an organ or tissue donation or transplantation.

12. **Deceased Individuals.** The health information of a deceased individual may be disclosed to coroners, medical examiners, and funeral directors so that those professionals can perform their duties.

Uses and Disclosures for Fundraising and Marketing Purposes

The Plan does NOT use your health information for fundraising or marketing purposes.

Uses and Disclosures of Genetic Information

The Plan is prohibited from using PHI that is genetic information for underwriting purposes with the exception of long term care insurance if offered.

Any Other Uses and Disclosures Require Your Express Authorization

Uses and disclosures of your health information ***other than*** those described above will be made only with your express written authorization, including the use or disclosure of psychotherapy notes. You may revoke your authorization in writing. If you do so, the Plan will not use or disclose your health information protected by the revoked authorization, except to the extent that the Plan already has relied on your authorization.

Once your health information has been disclosed pursuant to your authorization, the federal privacy protections may no longer apply to the disclosed health information, and that information may be re-disclosed by the recipient without your or the Plan's knowledge or authorization. However, you may revoke your authorization to use or disclose PHI, at any time by contacting the Privacy Officer. Such revocations of authorizations will be made on a prospective basis only.

YOUR HEALTH INFORMATION RIGHTS

You have the following rights regarding your health information that the Plan collects and maintains. If you are required to submit a written request related to these rights, as described below, you should address requests to the individual or department noted on page 1 of this Notice.

Right to Inspect and Copy Health Information

You have the right to inspect and obtain a copy of your health record. This includes, among other things, health information about your plan eligibility, plan coverages, claim records, and billing records.

To inspect and copy your health record maintained by the Plan, submit your request in writing. The Plan may charge a fee per page for the cost of copying your health record, and charge you the cost of mailing your health record to you. In certain limited circumstances, the Plan may deny your request to inspect and copy your health record. If the Plan does so, it will inform you in writing. In certain instances, if you are denied access to your health record, you may request a review of the denial.

Right to Request Confidential Communications, or Communications by Alternative Means or at an Alternative Location

You have the right to request that the Plan communicate your health information to you in confidence by alternative means or in an alternative location. For example, you can ask that the Plan only contact you at work or by mail, or that the Plan provide you with access to your health information at a specific location.

To request confidential communications by alternative means or at an alternative location, submit your request in writing. Your written request should state the reason(s) for your request and the alternative means by or location at which you would like to receive your health information. If appropriate, your request should state that the disclosure of all or part of your health information by non-confidential communications could endanger you. The Plan will accommodate reasonable requests and will notify you appropriately.

Right to Request That Your Health Information Be Amended

You have the right to request that the Plan amend your health information if you believe the information is incorrect or incomplete.

To request an amendment, submit a detailed request in writing that provides the reason(s) that support your request. The Plan may deny your request if you have asked to amend information that:

- Was not created by the Plan, unless you provide the Plan with information that the person or entity that created the information is no longer available to make the amendment;
- Is not part of the health information maintained by or for the Plan;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

The Plan will notify you in writing as to whether it accepts or denies your requests for an amendment to your health information. If the Plan denies your request, it will explain the reason(s) for the denial, and describe how you can continue to pursue the denied amendment.

Right to an Accounting of Disclosures

You have the right to receive a written accounting of disclosures. The accounting is a list of disclosures of your health information by the Plan to others, except that disclosures for treatment, payment or health care operations, disclosures made to or authorized by you, and certain other disclosures are not part of the accounting. The accounting covers up to six years prior to the date of your request, except that the accounting will not include disclosures of the Plan made before **April 14, 2004**. If you want an accounting that covers a time period of less than six years, please state that in your written request for an accounting.

To request an accounting of disclosures, submit your request in writing. The first accounting that you request within a 12-month period will be free. For additional accountings in a 12-month period, the Plan will charge you for the cost of providing the accounting, but the Plan will notify you of the cost involved before processing the accounting so that you can decide whether to withdraw your request before any costs are incurred.

You have the right to be notified in the event that we (or a business associate) discover a breach of unsecured PHI.

In addition, you have a right to receive reports of any security incidents that the Employer or a Participating Employer becomes aware of that is required under the Security Rules.

Right to Request Restrictions

You have the right to request restrictions on your health care information that the Plan uses or discloses about you to carry out treatment, payment or health care operations. Also, you have the right to request restrictions on your health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. The Plan is not required to agree to your request for such restrictions, and the Plan may terminate its agreement to the restrictions you requested.

To request restrictions, submit your request in writing, and advise the Plan as to what information you seek to limit, and how and/or to whom you would like the limit(s) to apply. The Plan will notify you in writing as to whether it agrees to your request for restrictions. The Plan will also notify you in writing if it terminates an agreement to the restrictions that you requested.

Right to Complain

You have the right to complain to the Plan and/or to the Department of Health and Human Services if you believe your privacy rights have been violated. To file a complaint with the Plan, submit your complaint in writing to the individual or department noted on page 1 of this Notice.

You will not be retaliated or discriminated against and no services, payment, or privileges will be withheld from you because you file a complaint with the Plan or with the Department of Health and Human Services.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. To make such a request, submit a written request to the individual or department noted on page 1 of this Notice.

CHANGES IN THE PLAN'S PRIVACY AND SECURITY PRACTICES

Changes in the Plan's Privacy Policies

The Plan reserves its right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail to your last-known address on file.

If the Plan materially changes any of its privacy or security practices, it will revise its Notice, and provide you with the revised Notice within 60 days of the revision. In addition, copies of the revised Notice will be made available to you upon your written request. The Plan also may decide to post the revised Notice at its office locations

.

SCHEDULES

SCHEDULE A
SCHEDULE OF BENEFITS

Contributory Benefits	Employee Cost Per Pay	Tax Status of Contributions
Medical (1)		
Single	(2)	Pre-tax/Post-tax
Employee + Spouse/Partner	(2)(3)	Pre-tax/Post-tax
Employee + Child(ren)	(2)(3)	Pre-tax/Post-tax
Family	(2)(3)	Pre-tax/Post-tax
Vision (1)		
Single	(2)	Pre-tax/Post-tax
Employee + Spouse/Partner	(2)(3)	Pre-tax/Post-tax
Employee + Child(ren)	(2)(3)	Pre-tax/Post-tax
Family	(2)(3)	Pre-tax/Post-tax
Dependent Care Spending Account	See Schedule C	Pre-tax Only
Healthcare Spending Account	See Schedule C	Pre-tax Only

Non-Contributory Benefit		
Waive out Option		Benefit will be taxable

(1) The exact insurance provider and Plan benefits offered will be communicated to participants during the annual enrollment period and to employees when they first become eligible for the Plan.
(2) The exact amount of any required contributions will be communicated to participants during the annual enrollment period and to employees when they first become eligible for the Plan.
(3) If coverage includes an individual who is not also your tax dependent or your child who is under age 27 as of the end of the tax year (December 31), your contributions for that individual must be made on a post-tax basis. Additionally, any employer contributions for such individuals will be subject to imputed income to the employee.

SCHEDULE B
INSURANCE CARRIERS AND CLAIMS ADMINISTRATORS [(1)]

Carrier/ Administrator	**Function**	**Contract Number**	**Funding**	**Benefits Covered**
Independence Blue Cross **1-800-ASK-BLUE** **www.ibx.com**	Insurer	POS: 10138608 PPO: 10093728	Fully-Insured – Contributory	Medical POS PPO
Vision Benefits of America (VBA) 1-800-432-4966 www.visionbenefits.com	Insurer	3490	Fully Insured Contributory	Vision
Discovery Benefits 1-866-451-3399 www.discoverybenefits.com	Claims Administrator	16903	Paid from General Assets Contributory	Spending Account Healthcare Dependent Care

(1) This schedule provides a description of coverage options and insurance carriers as of **August 1, 2015.** Available coverage options and insurance carriers may be changed at any time by the Employer.

SCHEDULE C
SPENDING ACCOUNTS

Employee Election	**Annual Minimum**	**Annual Maximum**
Healthcare Spending Account	$100	$1,500[(1)]
Dependent Care Spending Account	$100	$5,000[(2)(3)]

(1) **This amount does not include any carryover balance from the previous plan year. The maximum carryover amount permitted is $500 which is added to this amount.**

(2) **This amount must be reduced by any amounts your spouse is also contributing to an employer dependent care spending account.**

(3) **The maximum amount is reduced to the least of the following amounts:**

- **The amount noted above, annualized it is $5,000;**
- **$2,500 annually if you are married and filing separately;**
- **Your monthly income;**
- **Your spouse's monthly income; or**
- **If your spouse is a full-time student or unable to care for themselves, $250 per month for care of one dependent or $500 per month for the care of two or more dependents.**

SCHEDULE D
PARTICIPATING EMPLOYERS [1]

Philadelphia Redevelopment Authority

[1] **as of July 1, 2013**

SCHEDULE E
DEFINITIONS OF DEPENDENT
UNDER THE INTERNAL REVENUE CODE
FOR THE PURPOSE OF PLAN BENEFITS

The following is a summary of the definitions for dependents under the Code as they apply to individuals who also may be eligible for Plan benefits.

1. SEC. 152. DEPENDENT DEFINED FOR TAX PURPOSES

A Code §152 dependent is either a "qualifying child" or a "qualifying relative."

- A *qualifying child* is an individual who (a) bears a specified relationship to the employee (relationship test); (b) has the same principal abode as the employee for more than half of the year (residency test); (c) meets certain age requirements (age test); (d) has not provided more than half of his or her own support for the year (limited self-support test); and (5) has not filed a joint tax return (other than only for claim of refund) with his or her spouse for the year (marital/tax filing status test).
- A *qualifying relative* is an individual (a) who bears a specified relationship to the employee (relationship test); (b) whose gross income is less than the exemption amount in Code §151(d) (income test); (c) with respect to whom the employee provides over half of the individual's support (support test); and (d) who is not anyone's qualifying child.
- *Individuals Who Generally Are Ineligible Under Code §152.* An individual generally will not be a Code §152 dependent if he or she is a dependent of a Code §152 dependent, a married dependent filing a joint tax return, or a citizen or national of a country other than the United States.

2. SECTION 105(b) DEPENDENT FOR HEALTHCARE COVERAGE

Code §105(b) establishes the requirements that an individual must meet in order to be an employee's tax dependent for health coverage purposes. In order to be a Code §105(b) dependent, an individual must <u>meet most, but not all</u>, of the requirements to be a "qualifying child" or a "qualifying relative" under Code §152 as noted above

Specifically, the following individuals still can be an employee's tax dependents for health coverage purposes even though they **<u>do not</u>** meet the following criteria that otherwise apply to Code §152 dependents.

- There is no gross income limit. The employee only has to provide Code §105(b) dependent with more than half of the dependent's support.
- If married, the employee and Code 105 dependent do not have to file joint returns.
- The individual can be a Code §105 dependent if either a U.S. citizen, U.S. national or U.S. resident alien of the United States, or a resident of a country contiguous to the United States (Canada and Mexico) (exceptions exist for certain legal adoptions).

In addition, an employee's child who is under age 27 as of the end of the taxable year can obtain health coverage on a tax-free basis, even if the child does not qualify as the employee's tax dependent under either Code §152 or Code §105. Tax-free coverage can be available through the end of the calendar year in which the child attains age 26. The age limit, residency, support, and other tests that would otherwise have to be met in order for an individual to qualify as a tax dependent under the Code do not apply to such a child for purposes of the tax-favored treatment of health coverage that is available under Code §105(b).

3. HOUSEHOLD AND DEPENDENT CARE CREDIT

The Household and Dependent Care Credit is a nonrefundable tax credit available to United States taxpayers. Taxpayers that care for a qualifying individual are eligible. The purpose of the credit is to allow the taxpayer (or their spouse, if married) to be gainfully employed. This credit is created by 26 U.S.C. § 21, section 21 of the Internal Revenue Code (IRC).

The following is an overview of the eligibility criteria for a dependent under IRC 21. Employees may want to contact a tax or legal advisor to determine if an individual meets the requirements listed.

General Eligibility Requirements

IRC Section 21 uses the term "qualifying individual" rather than “dependent" to refer to the types of dependents that may permit an employee to receive a tax credit related to the care of the dependent. Qualifying individuals must be in one of the following groups:

- Dependents under age 13 for whom a dependency exemption may be claimed [(1)];
- Dependents of any age who share the same principal place of abode as the taxpayer and are physically or mentally incapable of taking care for themselves;
- Spouses of any age who share the same principal place of abode as the taxpayer and are physically or mentally incapable of taking care for themselves; or
- Certain dependent children of divorced parents.

Additional Eligibility Requirements

The taxpayer must “maintain the household” for the qualifying individual(s), which means the taxpayer must furnish over 1/2 of the total cost of maintaining the household. In addition, if the taxpayer is married, both the taxpayer and their spouse must have earned income, unless one spouse was either a full–time student or was physically or mentally incapable of self–care.

[1] A taxpayer can claim a dependency exemption for a dependent under the age of 13 if the dependent is the taxpayer's child, sibling, half-sibling, stepsibling or a descendant of any such individual. The qualifying child must not provide more than 1/2 of his or her own support and must have the same principal place of abode as the taxpayer for more than six months of the year.

SCHEDULE F
LIST OF STATES OFFERING ASSISTANCE FOR MEDICAL COVERAGE

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: 1-855-692-5447	Website: http://dch.georgia.gov/ - Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Website: http://www.in.gov/fssa Phone: 1-800-889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/ dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: http://medicaid.mt.gov/member Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633	Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: www.ohhs.ri.gov Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-866-435-7414	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

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