BENEFIT GUIDE

August 1, 2023—July 31, 2024

PHDC

MAKING PHILADELPHIA BETTER, BLOCK BY BLOCK

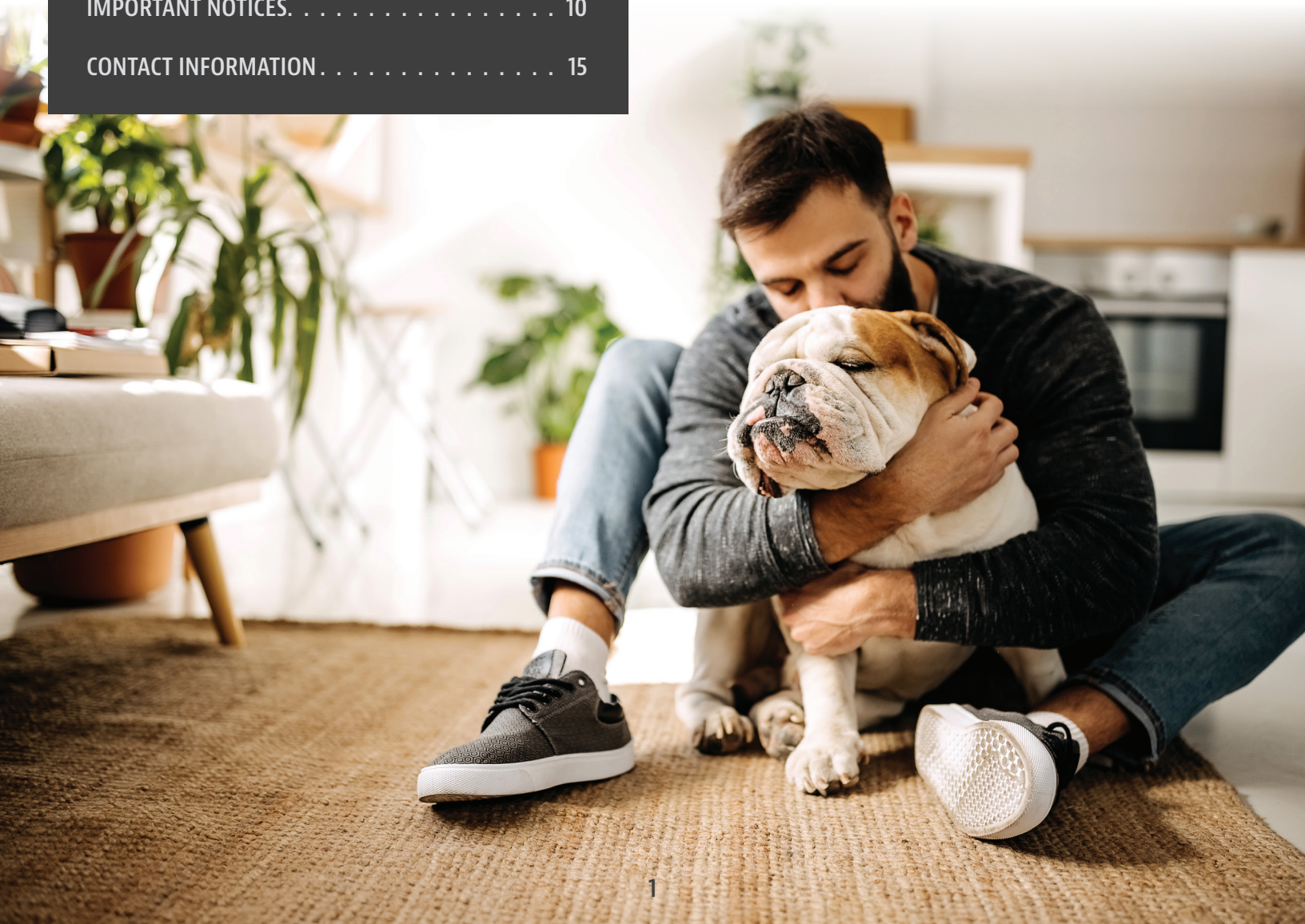
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 10 for more details and share this information with your dependents.

WELCOME

Contents

Welcome!

Philadelphia Housing Development Corporation (PHDC) is proud to provide our employees with a benefits program that offers choices designed to meet their individual needs and lifestyles. Each year, we review our benefit plan design to continually provide a comprehensive benefit package for our employees and their families. On the following pages, you will find a brief overview of our benefit plans. Please take the time to familiarize yourself with our benefits.



PLAN RULES & ELIGIBILITY

Benefits and Eligibility

All full-time employees are eligible to participate in the following benefit programs. All retirees can elect Medical & Prescription Drug, Dental and Vision for 5 years from the date of retirement. PRA and PHDC retirees receiving a PRA pension are covered for Life insurance benefits for 5 years from the date of retirement. PHDC retirees receiving a City Pension are covered for a $6,000 life insurance benefit for the duration of their retirement.

- Medical & Prescription Drug
- Dental
- Vision
- Flexible Spending Accounts – **Active employees only**
- Transportation Benefit – **Active employees only**
- Life and AD&D – **Active employees only**
- Voluntary Long Term Disability – **Active employees only**
- Voluntary Pet Insurance – **Active employees only**

DEPENDENT ELIGIBILITY

Employees and retirees who are eligible to participate in PHDC's benefit programs may enroll their dependents in the Medical & Prescription Drug, Dental, and Vision plans. Active employees can also enroll their dependents in spending accounts and voluntary insurance programs. For the purposes of our benefit plans, your dependents are defined as follows:

- Your spouse or domestic partner (same-sex)
  - Please note that health care expenses for domestic partners **are not** reimbursable under the Health Care Flexible Spending Account
- Your child(ren), or child(ren) of a domestic partner, who are under the policy's age limit, regardless of marital or student status
  - Medical & Vision: Age 26
  - Dental: Age 19 or 23 if full time student
- Your child(ren) over age 26 who are mentally or physically disabled and dependent upon you for support (proof of condition and dependency must be submitted)
- Your child(ren) who are covered by a Qualified Medical Child Support Order (QMCSO)

Changing Your Benefits

Per Internal Revenue Service (IRS) rules, employees enrolled in pre-tax benefit plans may only make elections or changes to their plans once per year. Because of these rules, your benefit elections will be binding through July 31, 2024. However, you may make changes to your election if you experience one or more of the following special circumstances, which are known as "Qualifying Life Events":

- Marriage or divorce
- Birth, adoption or placement for adoption of an eligible child
- Loss of spouse's job or change in work status (when coverage is maintained through spouse's plan)
- A significant change in your or your spouse's health coverage that is attributable to your spouse's employment
- Death of spouse or dependent
- Loss of dependent status
- Becoming eligible for Medicare or Medicaid during the year
- Receiving a Qualified Medical Child Support Order (QMCSO)

These qualifying life events allow you to make plan changes during the year. For any allowable changes, you must inform PHDC's Human Resources Department within 30 calendar days of the event. Benefit changes that are requested due to a "change of mind" cannot be allowed until the next Open Enrollment Period. For additional information concerning plan changes, please contact Human Resources.

MEDICAL & RX BENEFITS

Medical and Prescription Drug Benefits

To meet the diverse needs of PHDC's employees and their families, we offer two different medical and prescription drug options:

Keystone POS 1B	Personal Choice PPO 1B
» National network through IBC » Prescription drug covered through Optum » Preventive care, including routine screenings and checkups, covered at 100% » In and out-of-network coverage » **REQUIRES** PCP designation and referrals	» National network through IBC » Prescription drug covered through Optum » Preventive care, including routine screenings and checkups, covered at 100% » In and out-of-network coverage » **DOES NOT REQUIRE** PCP designation or referrals

To locate an in-network provider, visit www.ibx.com/providerfinder or call 1-800-ASK-BLUE.

Mail Order Program

If you are taking a maintenance medication for an ongoing or chronic condition, enroll in the mail order program to reduce your out-of-pocket costs. Your doctor can prescribe you a 90 day supply for a cost of two 30 day supply at a retail pharmacy. Plus, you can get it delivered securely to your home.

Virtual Care Benefit

As a member enrolled in medical and prescription coverage through IBC, you get access to telemedicine, tele-behavioral, and tele-dermatology services offered by MDLive. You and your enrolled dependents have 24/7 access to a U.S. board-certified and licensed providers by phone, video chat, or mobile app without leaving home or work. They can treat and prescribe medication (if needed). Telemedicine includes non-emergent conditions, such as sinus pain, pink eye, earaches, sore throat, and flu as well as also provides pediatric services. Tele-behavioral health includes conditions such as anxiety, depression, and panic disorders. Teledermatology includes more than 3,000 skin, hair, and nail conditions. To get started, visit www.mdlive.com/ibx or call 1-877-764-6605.

Member Portal and Additional Programs

Once you are registered, you can log on to www.ibxpress.com to:

- View your benefits, review claims and annual out-of-pocket expenses, and request replacement ID cards
- **Doctor and Hospital finder** – find participating providers and hospitals that are customized to your plan
- **Health Navigator** – decision tool on where to seek care based on your medical symptoms
- **Well-being Profile** – health survey that gives you a snapshot of your current health and provides a personalized report on recommended areas of improvement
- **Achieve Well-being** – interactive tools and resources to develop an action plan for your health goals
- **Nutrition Counseling** – schedule up to 6 visits a year with a participating registered dietitian at no cost
- **Acupuncture Benefit** – can receive up to 18 acupuncture visits a year if qualified based on condition; Members will pay a specialist copay if utilizing an in-network provider
- **Program Reimbursement** – get up to $150 when you are enrolled in an approved gym, participate in an approved weight management program, or complete a tobacco cessation program
- **Member Discounts** – great deals on gym memberships, weight loss programs, fitness apparel, amusement tickets, movies, museum attractions, sporting events, and more
- **College Tuition Benefit** – offers employees the opportunity to earn tuition credits each year to be used to pay for full time, undergraduate education at over 375 private colleges and universities; program is portable if the employee is no longer enrolled with IBC
- **GradFin Program** – provides members free, personalized solutions to accelerate their student loan debt payoff process
- **On To Better Health** – help members balance work and home responsibilities with free, confidential, online cognitive-behavioral programs
- **GlobalFit Anywhere** – access live virtual classes through the GlobalFit Anywhere app as well as purchase exercise classes, training sessions, and gym day passes at a discounted rate; members must be 18 or older

MEDICAL & RX HIGHLIGHTS

SUMMARY OF MEDICAL/PRESCRIPTION DRUG COVERAGE

	Keystone POS 1B	Personal Choice PPO 1B
In-Network Medical Benefits	**(You Pay)**	**(You Pay)**
PCP Designation & Referrals Required?	Yes	No
Calendar Year Annual Deductible (Individual/Family)	None / None	None / None
Calendar Year Out-of-Pocket Maximum Benefit (Individual/Family)	$7,150 / $14,300	$7,150 / $14,300
Preventive Care	$0 Copay	$0 Copay
Office Visit (PCP/Specialist)	$15 / $30 Copay	$10 / $20 Copay
Virtual Care	$15 Copay	$10 Copay
Urgent Care	$87 Copay	$87 Copay
Emergency Room (Copay Not Waived If Admitted)	$125 Copay	$125 Copay
Lab Services	$0 Copay	$0 Copay
Diagnostic X-Ray Services	$30 Copay	$20 Copay
Imaging Services (e.g. CT, PET Scans, and MRIs)	$60 Copay	$40 Copay
Hospital Inpatient	$100 Per Day Up To $500 Max Per Admission	$50 Per Day Up To $150 Max Per Admission
Outpatient Surgery	$50 Copay	$0 Copay
Out-Of-Network Medical Benefits		
Calendar Year Annual Deductible (Individual/Family)	$5,000 / $15,000	$1,500 / $4,500
Coinsurance	30%	30%
Calendar Year Out-of-Pocket Maximum (Individual/Family)	$30,000 / $90,000	$10,000 / $30,000
Prescription Drug Benefits		
Retail (30-day supply) Generic Brand Non-Formulary	 $10 Copay $20 Copay $35 Copay	 $10 Copay $20 Copay $35 Copay
Mail Order (90-day supply) Generic Brand Non-Formulary	 $20 Copay $40 Copay $70 Copay	 $20 Copay $40 Copay $70 Copay

Note: This summary is meant to provide a brief overview of medical benefits. In the event of a conflict, the plan documents will govern.

DENTAL BENEFITS

Dental Benefit

Good dental health is important to your overall well-being. That's why PHDC is pleased to offer employees a dental plan through Delta Dental of Pennsylvania. **All employees and retirees enrolling in Medical are automatically enrolled in Dental coverage at no cost**. You are not required to select a Primary Care Dentist under this plan. To find a provider, visit https://www.deltadentalins.com and select "Delta Dental PPO" as the network option.

The Delta Dental plan allows you to receive dental care from participating providers (in-network) and non-participating providers (out-of-network). Utilizing a participating dentist may result in additional savings because participating dentists have agreed to accept Delta Dental's fees for covered services. There is no balance billing for covered services when they are provided by a participating dentist.

If you choose to seek treatment from a non-participating dentist, you may be responsible for paying the balance of that dentist's fees that are above Delta Dental's allowed amount. Additionally, some out-of-network providers may require you to pay the entire billed amount at the time of service and then submit your claims for reimbursement.

REQUESTING A PRE-TREATMENT ESTIMATE

Before you have certain complex dental services performed (crowns, bridges, dentures, or periodontal work), you can request a pre-treatment estimate from Delta Dental, so you can appropriately budget for the services or discuss potential alternatives treatment options with your dentist. This estimate will give you information about what services are covered and for how much. For more information, you may contact Delta Dental at www.deltadentalins.com or call 1-800-932-0783.

SUMMARY OF DENTAL COVERAGE

	In-Network	Out-of-Network
Calendar Year Deductible	$25 Per Individual	$25 Per Individual
Preventive Services (Exams, cleanings, x-rays, sealants)	100%	100% Of Plan's Allowed Charges
Basic Services (Root canals, gum treatment, oral surgery, fillings, denture repair & relining)	100% After Deductible	100% Of Plan's Allowed Charges After Deductible
Major Services (Crowns, inlays, onlays, cast restorations)	80% After Deductible	80% Of Plan's Allowed Charges After Deductible
Implants	50% After Deductible	50% Of Plan's Allowed Charges After Deductible
Orthodontia (Children Up to Age 19, Deductible Waived)	80%	80% Of Plan's Allowed Charges
Calendar Year Maximum	$2,000 Per Individual	
Implants Lifetime Maximum	$1,500 per individual	
Orthodontia Lifetime Maximum	$2,000 Per Individual	

Note: This summary is meant to provide a brief overview of dental benefits. In the event of a conflict, the plan document will govern.

VISION BENEFITS

Vision Benefit

PHDC offers a vision plan through Vision Benefits of America (VBA). This plan allows you to receive an eye exam every 12 months and provides substantial savings on your eye care purchases. You also have the option of receiving care from participating providers (in-network) and non-participating providers (out-of-network). Dollar for dollar, you receive the best value from your vision benefit when you visit a participating provider. If you choose to use a non-participating provider, you will need to submit a claim form, available on the VBA website, to VBA by mail or fax with the itemized receipts.

For more information or to search for an in-network provider, you may visit vbaplans.com and fill in your zip code or call 1-800-432-4966.

SUMMARY OF VISION COVERAGE

	In-Network	Out-of-Network Reimbursement
Frequency Exams Lenses/Contact Lenses Frames	12 Months 12 Months 24 Months	
Eye Exams	$0 Copay	Up To $40
Standard Lenses Single Vision Bifocal Trifocal Progressive Lenticular	 $0 Copay $0 Copay $0 Copay $45 - $175 Allowance $0 Copay	 Up To $40 Up To $60 Up To $80 Up To $80 Up To $120
Frames	$125-$150 Allowance	Up To $50
Contact Lens (In Lieu Of Glasses) Elective Medically Necessary	 Up to $110 Allowance $0 Copay	 Up To $110 Up To $320
Lens Options Polycarbonate (Children Under Age 19) Scratch Coating	 $0 Copay $0 Copay	 Not Covered Not Covered

Note: This summary is meant to provide a brief overview of vision benefits. In the event of a conflict, the plan document will govern.

SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) – **Active Employees Only**

PHDC allows you to redirect a portion of your pre-tax pay into Flexible Spending Accounts (FSAs). Since these deductions are calculated without Federal and Social Security taxes included, your taxable income is lower and your spendable income is potentially higher. This benefit is provided by Wex.

Please remember to keep all receipts! It is necessary for you to save your receipts for all eligible medical and dependent care expenses. Even though the expense was paid with the debit card, the IRS requires every transaction to be validated to ensure it is health or dependent care related. In some instances, the expense cannot be automatically substantiated or validated. In these instances, you will receive a request to provide a receipt as validation. **Failure to provide receipts when requested may cause your FSA card to be frozen until proper substantiation is provided**.

HEALTH CARE FLEXIBLE SPENDING ACCOUNTS

You may set aside an annual amount up to $3,050 on a pre-tax basis to use towards health care purchases. These purchases include medical copays, prescription drug copays, dental costs not covered by insurance, vision costs not covered by insurance as well as other items. Participants are able to rollover $610 of unused healthcare FSA funds at the end of the plan year. Your annual contribution is divided by your number of pay periods, and that amount will be deducted pre-tax each pay period. The amount you elect may not be changed or revoked during the plan year unless you experience a qualifying life event.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

This spending account allows you to set aside a portion of your pay on a pre-tax basis to pay for eligible dependent expenses so that you and your spouse can work. Generally, expenses will qualify for reimbursement if they are the result of care for:

- Your children, under the age of 13, for whom you are entitled to a personal exemption on your federal income tax return.
- Your spouse or other dependent, including parents, who are physically or mentally incapable of self-care.

You can set aside an annual amount up to $5,000 ($2,500 if married and filing separately). At the end of the plan year, any amount that is left over will be "forfeited."

SPENDING ACCOUNTS

Transportation Benefit – **Active Employees Only**

PHDC provides a transit benefit, which allows you to set aside pre-tax dollars to pay for expenses related to commuting to and from work as well as work-related parking costs. This includes transit passes, tokens, vouchers, parking passes, vanpooling, and more. Once enrolled, you will get a debit card that you will use to pay for such expenses. The monthly contribution limit for transit and parking expenses is $300. You will not pay federal income or FICA taxes on these dollars. This benefit is provided to you through Wex.

Wex Debit Card and Member Portal

You will receive a VISA debit card from Wex that you can use for qualified expenses. The card is a "Smart Card" that will automatically apply your charges to the correct bucket – FSA or transit.

You can manage your benefits, view account activity, check your balance, and upload receipts to file a claim, online or via mobile app once you have created an account through the Wex member portal. Visit https://www.wexinc.com for more information.

ADDITIONAL BENEFITS

Life and Accidental Death and Dismemberment (AD&D)

BASIC LIFE AND AD&D

- Active PHDC employees who are former PRA employees have Life and AD&D insurance through The Standard at no cost for a benefit amount of one times annual earnings, rounded to the next highest $1,000 to a maximum $100,000 without evidence of insurability. Retirees receiving a PRA pension are covered by this benefit for 5 years from the date of retirement.
- Active PHDC employees who are enrolled in one of the City of Philadelphia's pension plans, have Life & AD&D insurance through Securian/Minnesota Life at no cost for a benefit amount of $20,000. Retirees are eligible for $6,000 for their lifetime from the date of retirement. View your life insurance coverage certificate from a City computer only: http://personnel-web.phila.gov/benefits/grouplife. To continue your life insurance coverage after employment ends, and get information, forms, and calculate rates, visit www.lifebenefits.com/continue and Enter policy #: 34021, Access key: Philadelphia. Call 866-365-2374 for website assistance. You have 60 days from the date your employment ends to convert your coverage.

VOLUNTARY LIFE AND AD&D – ACTIVE EMPLOYEES ONLY

- Active PHDC employees who are former PRA employees can purchase additional Voluntary Life coverage through the Standard. You will have to complete a health questionnaire if enrolling for the first time, and may need to complete a health questionnaire if increasing your coverage amounts.
- Active PHDC employees who have pension benefits through the City of Philadelphia, can purchase additional Voluntary Life and AD&D coverage through Securian. You can purchase coverage for yourself, spouse and children.

Voluntary Pet Insurance – **Active Employees Only**

PHDC has partnered with Nationwide to get you preferred pricing on pet insurance. Nationwide's Voluntary Pet Insurance plans reimburse eligible veterinary expenses relating to accidents, illnesses and injuries for dogs, cats, birds, reptiles and exotic pets. Coverage is accepted by veterinarians everywhere. Optional wellness protection coverage is also available for routine preventive exams and services. Lump sum benefit amount is based on type of coverage and elected reimbursement level. This benefit is offered on a voluntary basis and deductions will be taken out of your paycheck. To enroll, visit https://benefits.petinsurance.com/phdcphila or call 1-877-738-7874 and mention "Philadelphia Housing Development Corporation employee."

Voluntary Long Term Disability (LTD) – **Active Employees Only**

You may select a monthly benefit amount in $100 increments (based on the table and guidelines within plan documents). The monthly benefit amount must not exceed 60% of your monthly earnings. The maximum monthly benefit is $6,000; the minimum benefit is $200. You may also elect a benefit waiting period, which is the period of time that you must be continuously disabled before benefits become payable. The waiting period options are listed below. If you do not elect this benefit when you are first eligible, you will be able to elect or make changes during open enrollment. Cost will be paid by you and based on your benefit amount and waiting period elections.

VOLUNTARY LTD WAITING PERIOD

Accidental Injury	Other Disability
0 days	7 days
14 days	14 days
30 days	30 days
60 days	60 days
90 days	90 days
180 days	180 days

Medicare Help Team

Employees nearing age 65 and/or retirement, have access to Medicare education, guidance, and assistance through HTA Financial Services at no cost. These licensed experts can help you transition to Medicare, acquire appropriate coverage to meet your needs, and provide ongoing support. You start with a one-on-one phone counseling session, where they will prepare and answer questions for all aspects of retirement healthcare. From that consultation, they provide you with a "roadmap" with step-by-step action items leading up to retirement. When it is time to make your decision, they will educate you on the Medicare Onboarding process, explain each product offered, and assist with the complete of enrollment. If any questions or assistance is needed in the future, you will have unlimited phone support. To set up a phone consultation, call 610-430-6650. If you are seeking advice on prescriptions, please make sure to have your prescriptions ready for the call.

IMPORTANT NOTICES

Medicare Part D – Creditable Coverage

Important Notice from Philadelphia Housing Development Corporation (PHDC) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your 2022 prescription drug coverage with PHDC and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. PHDC has determined that the prescription drug coverage offered by the IBC POS and PPO plans are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current PHDC coverage will not be affected. You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage. Please see pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current PHDC coverage, be aware that you and your dependents will need to wait until PHDC's next open enrollment period to be able to re-enroll in PHDC's medical/prescription drug program.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with PHDC and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through Philadelphia Housing Development Corporation (PHDC) changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER: KEEP THIS CREDITABLE COVERAGE NOTICE. IF YOU DECIDE TO JOIN ONE OF THE MEDICARE DRUG PLANS, YOU MAY BE REQUIRED TO PROVIDE A COPY OF THIS NOTICE WHEN YOU JOIN TO SHOW WHETHER OR NOT YOU HAVE MAINTAINED CREDITABLE COVERAGE AND, THEREFORE, WHETHER OR NOT YOU ARE REQUIRED TO PAY A HIGHER PREMIUM (A PENALTY).

Date: August 2023

Name of Entity/Sender: Donna Trent

Contact — Position/Office: Vice President of Human Resources

Address: 1234 Market Street, 16th Floor, Philadelphia, PA 19107

Phone Number: 215-448-3076

IMPORTANT NOTICES

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 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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid

Website: http://myalhipp.com
Phone: 1-855-692-5447

ALASKA – Medicaid

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid

Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp
Phone: 916-445-8322
Fax: 916-440-5676
Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

Health First Colorado Website: https://www.healthfirstcolorado.com
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/ State Relay 711
Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – Medicaid

GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162, Press 1
GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra
Phone: (678) 564-1162, Press 2

INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/
Healthy Indiana Plan for low-income adults 19-64 Phone: 1-877-438-4479
All other Medicaid Website: https://www.in.gov/medicaid/
All other Medicaid Phone 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website: https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
HIPP Phone: 1-888-346-9562

KANSAS – Medicaid

Website: https://www.kancare.ks.gov
Phone: 1-800-792-4884
HIPP Phone: 1-800-766-9012

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718
Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US
Phone: 1-800-442-6003 / TTY: Maine relay 711
Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms
Phone: 1-800-977-6740 / TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840 / TTY: 617-886-8102

IMPORTANT NOTICES

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633 / Lincoln: 402-473-7000 / Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext. 5218

NEW JERSEY – Medicaid and CHIP

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx
Phone: 1-800-692-7462
CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov)
CHIP Phone: 1-800-986-KIDS (5437)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Website: https://www.coverva.org/en/famis-select
https://www.coverva.org/en/hipp
Medicaid/CHIP Phone: 1-800-432-5924

WASHINGTON – Medicaid

Website: https://www.hca.wa.gov
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP

Website: https://dhhr.wv.gov/bms
http://mywvhipp.com
Medicaid Phone: 304-558-1700
CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility
Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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**

IMPORTANT NOTICES

Children's Health Insurance Program Reauthorization Act

Effective April 1, 2009 employees and dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

» The employee's or dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminates because the individual ceased to be eligible.

» The employee or dependent becomes eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).

Employees must request this special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Consolidated Omnibus Budget Reconciliation Act

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employers who provide medical coverage to their employees to offer such coverage to employees and covered family members on a temporary basis when there has been a change in circumstances that would otherwise result in a loss of such coverage [26 USC §4980B]. This benefit, known as "continuation coverage," applies if, for example, dependent children become independent, spouses get divorced, or employees leave the employer.

Employee Retirement Income Security Act

Federal law imposes certain requirements on employee benefit plans voluntarily established and maintained by employers. [29 USC § 1001 et. seq.; 29 CFR 2509 et. seq.] ERISA covers two general types of plans: retirement plans, and welfare benefit plans designed to provide health benefits, scholarship funds, and other employee benefits. ERISA facilitates portability and continuity of health insurance coverage as a result of added provisions under the Health Insurance Portability and Accountability Act (HIPAA). It also covers continued health care coverage rules mandated under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Genetic Information Non-Discrimination Act

GINA broadly prohibits covered employers from discriminating against an employee, individual, or member because of the employee's "genetic information," which is broadly defined in GINA to mean (1) genetic tests of the individual, (2) genetic tests of family members of the individual, and (3) the manifestation of a disease or disorder in family members of such individual. GINA also prohibits employers from requesting, requiring, or purchasing an employee's genetic information. This prohibition does not extend to information that is requested or required to comply with the certification requirements of family and medical leave laws, or to information inadvertently obtained through lawful inquiries under, for example, the Americans with Disabilities Act, provided the employer does not use the information in any discriminatory manner. In the event a covered employer lawfully (or inadvertently) acquires genetic information, the information must be kept in a separate file and treated as a confidential medical record, and may be disclosed to third parties only in very limited circumstances.

HIPAA Information Notice of Privacy Practices

In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), your employer recognizes your right to privacy in matters related to the disclosure of health-related information. The Notice of Privacy Practices (provided to you upon your enrollment in the health plan) details the steps your employer has taken to assure your privacy is protected. The Notice also explains your rights under HIPAA. A copy of this Notice is available to you at any time, free of charge, by request through your Human Resources Department.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

IMPORTANT NOTICES

Newborn's Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

Qualified Medical Child Support Order

A QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Special Enrollment Rights

If you have previously declined enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement of adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Uniformed Services Employment and Reemployment Rights Act

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Women's Health and Cancer Rights Act (Janet's Law)

The Women's Health and Cancer Rights Act requires that all medical plans cover breast reconstruction following a mastectomy. Under this law, if an individual who has had a mastectomy elects to have breast reconstruction, the medical plan must provide the following coverage as determined in consultation with the attending physician and the patient:

» Reconstruction of the breast on which the mastectomy has been performed;

» Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

» Prostheses and physical complications at all stages of the mastectomy, including lymphedemas

Benefits received for the above coverage will be subject to any deductibles and coinsurance amounts required under the medical plan for similar services. The Act prohibits any group health plan from:

» Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act;

» Penalizing, reducing, or limiting reimbursement to the attending provider (e.g. physician, clinic or hospital) to induce the provider to provide care inconsistent with the Act; and providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the Act.

CONTACT INFORMATION

MEDICAL AND PRESCRIPTION DRUG BENEFITS

Independence Blue Cross (IBC)

IBC Member Services
www.ibxpress.com
800-275-2583

Mail Order/Pharmacy Services
(Administered by Optum)
888-678-7012

To find a provider:
Visit: www.ibx.com/providerfinder

Network: "Keystone HMO/POS/Direct POS" or "Personal Choice PPO"

Virtual Care through MD Live
1-877-764-6605
www.mdlive.com/ibx

DENTAL BENEFITS

Delta Dental of Pennsylvania

https://www.deltadentalins.com
1-800-932-0783

To find a provider:
Visit: www.deltadentalins.com

Network: Delta Dental PPO

VISION BENEFITS

Vision Benefits of America (VBA)

www.vbaplans.com
1-800-432-4966

FLEXIBLE SPENDING ACCOUNTS AND TRANSPORTATION BENEFIT – ACTIVE EMPLOYEES ONLY

Wex

https://www.wexinc.com
1-866-451-3399

LIFE INSURANCE BENEFITS

The Standard
Active employees who are former PRA employees and retirees receiving a PRA pension

www.standard.com
1-888-937-4783

Securian (Minnesota Life)
Employees & retirees receiving pension benefits through the city

www.lifebenefits.com
To file a claim: 215-686-0859

DISABILITY BENEFITS – ACTIVE EMPLOYEES ONLY

The Standard

www.standard.com
1-888-937-4783

VOLUNTARY PET INSURANCE – ACTIVE EMPLOYEES ONLY

Nationwide

https://benefits.petinsurance.com/phdcphila
1-877-738-7874 and mention "Philadelphia Housing Development Corporation employee"

MEDICARE HELP TEAM

HTA Financial Services

https://htafinancial.com/schedule/

Medicare@HTA-insurance.com
610-430-6650

Have Benefit Questions?

NFP BENEFITS SUPPORT TEAM

Our employee benefits consulting firm, NFP, provides a dedicated benefits support team who can answer your benefit plan questions and assist you in resolving benefit claim issues. This confidential service is available to you, as well as your family members who are covered by PHDC's benefits. You can reach the NFP team at: **855-287-2202** (toll free), between 8:00 a.m. and 5:00 p.m. Eastern Time, Monday through Friday; or by email at: BenefitsSupportTeamCSMidAtlantic@nfp.com

Benefit Resources

DETAILED PLAN SUMMARIES, SBCs, AND RESOURCES

Learn about all of the benefits you and your family are eligible for in one place. Find links to carrier documents and websites that will present detailed information for all of your company-provided benefits.

View your online resources by visiting:
https://mybenefits.nfp.com/PHDC/2023/resources