WELCOME

Dear VEBA HRA Participant:

Welcome to your City of Burbank VEBA Post Employment Health Reimbursement Arrangement ("VEBA HRA"). Please carefully review this brochure regarding your VEBA HRA account.

The VEBA HRA Plan third-party administration (TPA) service provider is Rehn & Associates. You will receive a quarterly statement detailing your account activity. If you have questions, you may contact the TPA service provider at the toll-free number on the front of this brochure. The TPA service provider maintains plan records and accounts.

In the event of a discrepancy between this Plan Summary and the Plan and Trust documents, the Plan and Trust documents control. This Plan Summary supersedes any previously published Plan descriptive materials. The Plan is not to be construed as giving you any rights against the Plan except those expressly described in this document.

Plan Summary

January 2016

City of Burbank VEBA HRA
Third-party Administration (TPA) Service Provider
Rehn & Associates
P.O. Box 5433
Spokane, WA 99205-0433
1-800-VEBA101 (832-2101)
Fax: (509) 535-7883
burbank@rehnonline.com

Plan Consultant
Gallagher VEBA, a Division of Gallagher Benefit Services, Inc.
906 West 2nd Avenue, Suite 400
Spokane, WA 99201-4537
1-800-888-VEBA (8322)
Fax: (509) 838-5613

Trustee
Washington Trust Bank
Spokane, WA

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PART I

Questions & Answers

What is the City of Burbank VEBA HRA?
This is the City's post-employment health reimbursement arrangement plan or "VEBA HRA" plan. After you leave City employment, VEBA HRA will provide you a source of funds to use for medical, dental, vision, or tax-qualified long-term care insurance premiums and/or non-covered medical, dental, or vision costs.

What is the history of plan amendments?
The last Plan amendment took place effective January 1, 2014. The Plan was amended to:
1) incorporate a pre-Medicare limited-scope election for participants who want to become eligible for the Premium Tax Credit, 2) allow participants to permanently waive or forfeit their HRA balance in order to become eligible for the Premium Tax Credit, 3) require employees who are subsequently re-hired by the City to be ineligible to file claims for benefits during their period of re-employment, 4) eliminate the provision allowing for claims payments due to a catastrophic medical expense prior to separation from service, and 5) document the Plan uses of Protected Health Information (PHI) and permit the City to receive certain PHI for plan administrative functions. All changes were required by law to comply with regulatory guidance.

The previous plan amendment took place on January 1, 2012. The Plan was amended to:
1) add language to clarify expenses eligible for reimbursement, 2) confirm the order of reimbursement between a Section 125 health FSA and VEBA HRA, 3) eliminate payments from accounts and provide for reimbursements only, and 4) update the internal and external claims appeal process to be consistent with the health care reform regulations.

The previous plan amendment took place on January 4, 2011. The Plan was amended to:
1) eliminate the heir death benefit to comply with IRS guidance, 2) include this Plan Summary as part of the governing documents, 3) amend the unclaimed property provisions so that such funds are reallocated to remaining participants rather than turned over to the State of California, 4) extend benefits to children of participants through the end of the year in which they turn age 26, and reimbursements for over-the-counter (OTC) drugs and medicines were limited due to recently enacted health care reform legislation, and 5) include references to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical (HITECH) Act.

An earlier plan amendment took place on July 1, 2003. The Plan was amended to limit benefits to medical reimbursements, and severance, education, and cash-out death benefits were eliminated as well. The amendments were made to comply with IRS guidance that had been recently issued regarding health reimbursement arrangement plans. In addition, a new third-party administration (TPA) service provider, trustee, attorney, and consultant were retained based upon their experience with VEBAs and HRAs. In 2003, participants were also provided the ability to direct their own investments, and when eligible, file medical claims at any time, with reimbursements paid weekly by the VEBA HRA TPA service provider.

Who is eligible for contributions to the VEBA HRA Plan?
Currently, Burbank Police Officers' Association (BPOA) members are eligible for monthly contributions equal to 1.5% of salary, 100% of retiree sick leave cash out (which is equal to 70% of the total value of unused accrued sick leave), and flat monthly contributions that will be adjusted periodically by the City. Other employees, both represented and non-represented, may be eligible for contributions when collective bargaining agreements, employer policy, or city resolution are amended to provide for such contributions.

When may I file claims and get money from my VEBA HRA?
You will be eligible for reimbursements from your VEBA HRA account after you separate from service.

What are eligible VEBA HRA expenses?

Eligible expenses include qualified medical, dental, and vision expenses not covered by your insurance plans, or medical, dental, and vision insurance premiums (including CalPERS premiums), Medicare Part B and Part D, Medicare supplement, and tax-qualified long-term care insurance premiums. Eligible expenses are defined in Internal Revenue Code Section 213(d). Purchases of certain over-the-counter (OTC) medicines and drugs made prior to January 1, 2011, if properly substantiated, qualify for reimbursement. After January 1, 2011, the law permits expenses for OTC medicines and drugs (other than insulin) to be reimbursed only if documentation is provided that the drug was prescribed. A sample list of qualified expenses is available online at **www.burbank.rehnonline.com**.

Insurance premiums paid by an employer, or premiums that are or could be deducted pre-tax under your employer's Section 125 cafeteria plan, are not eligible for reimbursement. Premiums deducted from your spouse's paycheck after tax may be eligible for reimbursement. In addition, premiums subsidized by the Premium Tax Credit may not be reimbursed from your VEBA HRA account because IRS rules do not permit you to receive two tax advantages on the same expense (i.e. cannot use tax-free VEBA HRA funds to reimburse premiums that are subsidized by the Premium Tax Credit). If you are not claiming or receiving the Premium Tax Credit for insurance purchased through a marketplace exchange, this limitation will not apply to you.

Note: If you elect limited purpose VEBA HRA coverage or pre-Medicare limited-scope coverage, your account will be limited to the reimbursement or certain expenses for a period of time which is described in more detail later in this section.

Whose expenses are eligible?

Expenses incurred by you, your legal spouse, and your qualified children and dependents are eligible for reimbursement. Qualified dependents are defined in IRC § 105(b), and described in IRS Publication 502. You may obtain IRS publications by calling 1-800-TAXFORM or by visiting www.irs.gov.

What happens to my account if I separate from service and later am reemployed by the City?

If you separate from service and subsequently return to employment with the City, you will not be eligible to file claims for qualified expense reimbursements during any period of reemployment. However, once you end your period of reemployment, you will be eligible to file claims once again. Your VEBA HRA account will not be affected if you are employed or reemployed by any other employer; only by reemployment with the City.

How do I file a claim for benefits?

When you separate from service, the City will send the TPA service provider notice of your separation. The TPA service provider will then mail you a claims packet including the following:

- VEBA HRA Claim Form
- VEBA HRA Automatic Premium Reimbursement Form

When you or a qualified child or dependent incur a qualified expense you may complete and submit a Claim Form to the TPA service provider along with proper documentation of your expense, such as a detailed receipt or an EOB (Explanation of Benefits) from your insurance provider. Reimbursements for benefits are limited to the amount of your account balance. Claims are paid weekly.

NOTE: Reimbursable health related benefits must be for expenses incurred after you separate from service. If you are claims-eligible and are a current participant in a Section 125 Health Care Flexible Spending Account (FSA), you must exhaust the FSA benefits before you may file an eligible VEBA HRA claim.

Can my VEBA HRA automatically reimburse my insurance premiums?

Yes, so long as they are not paid by an employer or deducted on a pre-tax basis through a Section 125 cafeteria plan, or subsidized by the Premium Tax Credit for insurance purchased through a marketplace exchange. Simply complete the VEBA HRA Automatic Premium Reimbursement Form and the TPA service provider will begin automatic reimbursement of your qualified

insurance premium(s). If your spouse or qualified children and dependents are covered by different medical plans, their insurance premiums can also be reimbursed from your account. Direct deposit for this reimbursement is available and recommended. Funds availability is subject to your banking institution's policies and procedures.

If CalPERS deducts my medical insurance premiums from my pension, can I request a reimbursement for the payment?

Yes. If CalPERS is deducting your medical insurance premium from your pension check, you may file a VEBA HRA Automatic Premium Reimbursement Form with the TPA service provider and request a reimbursement of your premium amount. You only need to file this form one time to receive a monthly reimbursement deposited directly to your checking or savings account. **Note: You will need to notify the TPA service provider each year if your premium amount changes so that your reimbursement may be changed accordingly.**

What is the death benefit?

If the participant dies with a positive participant account balance, his/her surviving spouse, if any, may file claims for eligible medical benefits incurred by the participant, the surviving spouse, and any other qualified children or dependents. If a participant dies without a surviving spouse and with dependent(s), the guardian(s) of the dependent(s) may file claims for eligible medical benefits on behalf of the dependent(s). At the death of the participant with no surviving spouse or qualified dependents, the executor or administrator of that person's estate may file claims for any eligible expenses incurred by that person, after which the participant account shall be forfeited per the terms of the Plan Document. IRS Revenue Ruling 2006-36 does not permit the payment of benefits to non-dependent heirs.

What is a VEBA and what are the tax objectives of the VEBA Plan?

VEBA stands for "voluntary employees' beneficiary association" and is a tax-exempt trust authorized by Internal Revenue Code Section 501(c)(9). The tax objectives of this type of plan are:

1. To enable your employer to make tax-free deposits on your behalf to the Plan;
2. To credit your account with tax-free investment earnings; and
3. To enable you to obtain tax-free reimbursements for your qualified medical expenses and insurance premiums.

VEBA contributions are not reportable on your Form W-2. You do not report VEBA contributions, earnings, or benefit payments on your individual 1040 Federal income tax form.

How are my funds invested?

You may choose from among five investment funds. You may have your VEBA funds invested in one, two, three, four, or all five of the investment funds, and you may change your investment allocations as often as once per calendar month.

Family/Investment	**Investment Objective**
Vanguard Short-Term Bond Index Fund	Seeks to track performance of a market-weighted bond index with a short-term dollar-weighted average maturity
Vanguard Total Bond Market Index Fund	Seeks to track performance of a broad, market-weighted bond index
Janus Adviser Balanced Fund	Long-term capital growth, consistent with preservation of capital and balanced by current income
Vanguard Institutional Index Fund (S&P 500)	Seeks to track performance of Standard & Poor's 500 Index
Sit Small Cap Growth Fund	Maximization of long-term capital appreciation

Who is the VEBA HRA Plan third-party administration (TPA) service provider?
Rehn & Associates in Spokane, Washington is the VEBA HRA Plan TPA service provider. Founded in 1961, Rehn & Associates is an experienced employee benefits administrator with highly trained staff specializing in the administration of health reimbursement plans. The TPA service provider provides all correspondence, accounting and benefit-payment services. Please immediately notify the TPA service provider of any address, name, or automatic premium reimbursement changes.

Can I view my account information online?
Yes. You may log in to your account at **www.burbank.rehnonline.com** to view your personal account information (including account balance, detailed account activity, and investment fund allocation), change your fund allocations, and change your address. Initial login instructions are contained in your welcome letter from the TPA service provider, and on your quarterly account statement. You may also contact the TPA service provider for login assistance.

Will I receive a statement of my account?
Yes. You will receive a quarterly statement detailing all activity in your account. You may also call or e-mail the TPA service provider with a request for additional statements at any time. If you have questions about your account, or about a pending claim, or need claim forms, contact the VEBA HRA TPA service provider. You may also view your personal VEBA HRA account online, including your account balance, detailed account activity, investment fund allocation, plus change your fund allocations, change your address, etc. You can log in to your account at **www.burbank.rehnonline.com**.

How do I qualify for the Premium Tax Credit if I purchase insurance through a state or federal marketplace exchange?
To qualify for the Premium Tax Credit, you may need to first use up or forfeit your VEBA HRA account, or elect Pre-Medicare Limited-Scope Coverage. For any month that you are claims-eligible and have a positive account balance in your VEBA HRA account, you may not qualify for the Premium Tax Credit unless you take certain action. For more information about your VEBA HRA account and Premium Tax Credit eligibility, read Part VIII Facts About Premium Tax Credit Eligibility in this Plan Summary. To learn more about Pre-Medicare Limited-Scope Coverage or forfeiture of your account, see the questions below.

How do I use up my account to qualify for the Premium Tax Credit?
You do not have to take the Premium Tax Credit right away. You could first use up your VEBA HRA account by filing claims for expenses, such as non-subsidized premiums and any other qualified health care expenses. However, keep in mind you will lose eligibility for the Premium Tax Credit for any months that you have a positive balance in your VEBA HRA account.

What is Pre-Medicare Limited-Scope Coverage?
Pre-Medicare Limited-Scope Coverage is optional and may be elected to qualify for the Premium Tax Credit through a state or federal marketplace exchange. If you make this election, your account will reimburse only expenses and premiums for certain dental, vision, and long-term care coverage (subject to IRS limitations) until you become Medicare-eligible either by age or permanent disability. **Note: This election will remain in force with respect to any expenses you incur after the date you make the election and until you turn age 65 (or earlier upon death or Medicare eligibility due to permanent disability), at which time your account may be converted back to full coverage for all types of qualified medical expenses and premiums.**

Why would I want to elect to forfeit future reimbursements?
If you choose not to elect Pre-Medicare Limited-Scope Coverage, you have the right under the VEBA HRA Plan and under federal health care reform law to permanently forfeit or give up all future reimbursements from any amounts currently held in your account or that may be contributed in the future. **This election is permanent and means that you are giving up your account and forfeiting future reimbursements from the VEBA HRA Plan.**

Please contact the TPA service provider to discuss your options and this election.

What is Limited Purpose VEBA HRA coverage and why would I elect it?

Limited Purpose VEBA HRA coverage is optional and you may choose to elect it to become eligible to contribute to a health savings account (HSA). If you elect limited purpose coverage, your account will cover only the following types of expenses: (1) standard dental care services (not related to a medical condition or accident), including dentures; (2) orthodontia; and (3) routine eye exams, contact lenses, and eyeglasses (excluding initial lenses and standard frames after cataract surgery). All other expenses incurred while coverage is limited, including qualified insurance premiums, are not covered.

Limiting your VEBA HRA coverage is one of the requirements you must meet in order to become eligible to contribute to a health savings account (HSA). To limit withdrawals from your VEBA HRA account, simply submit a completed and signed Limited Purpose VEBA HRA Form. If you have any questions, please contact the TPA service provider.

Limited purpose VEBA HRA coverage will constitute minimum essential coverage, as defined under section 5000A of the Internal Revenue Code, and will not be effective to cause you to become potentially eligible for the Premium Tax Credit. Read Part VIII Facts About Premium Tax Credit Eligibility for more information.

What are the VEBA HRA Plan expenses? Who pays them and how much are they?

Ongoing Plan expenses are paid by plan participants. The City and BPOA paid for part of the plan amendment and plan updating costs. Plan expenses include such items as: fees for plan administration, legal, consulting, trustee, printing, postage, investment management, auditing, mail service, banking, etc. Plan expenses shall be deducted from participant accounts each month on a per-capita basis and will fluctuate month to month. Small inactive accounts (those under $500 without any deposits for 12 months) will be charged an additional $5.00 fee per month.

Who is the Trustee of the Plan?

Washington Trust Bank in Spokane, Washington is the Trustee of the Plan.

What if I retire and move out of state?

If you retire and move out of state, your benefits will be available to you until you use them up. You may use the VEBA HRA benefits for any qualified medical expense regardless of where you live.

Will the Plan always be available?

While it is the intention of the City to continue to make the Plan available indefinitely, the City retains the right to discontinue the Plan subject to the provisions of collective bargaining. If the Plan were to be discontinued, Plan assets would be treated in accordance with the terms of the Plan Document.

What about amendments or termination of the Plan?

The City reserves the right to amend or discontinue offering the Plan. In the event of Plan termination, you may receive your Plan account balance, plus investment income. At that time, you can assume that your Plan account balance and investment income would be taxable. Plan amendment may not cause forfeiture or reduction of benefits.

Where do I get more information?

Check with the City of Burbank Management Services Department for Plan information, or call the VEBA Plan TPA service provider.

City of Burbank
Management Services Department
301 East Olive Avenue
Burbank, CA 91502
Benefits Information:
Phone: (818) 238-5003
Fax: (818) 238-5037

VEBA Third-party Administration (TPA) Service Provider
Rehn & Associates
P.O. Box 5433
Spokane, WA 99205-0433
Phone: 1-800-VEBA101 (832-2101)
E-mail: burbank@rehnonline.com
Website: www.burbank.rehnonline.com

VEBA Plan Consultant
Gallagher VEBA, a Division of Gallagher Benefit Services, Inc.
906 West 2nd Avenue, Suite 400
Spokane, WA 99201-4537
Mark R. Wilkerson
Miriam Woodard, CEBS®

Legal Counsel
Katten Muchin Rosenman LLP
525 West Monroe Street
Chicago, IL 60661-3693
Russell Greenblatt

PART II

Other Plan Information

The name of the Plan and Trust is the City of Burbank Welfare Benefit Plan. The Plan is commonly referred to as VEBA HRA.

The assets of the Plan are held in a trust. Washington Trust Bank has been named trustee.

Washington Trust Bank
Attn: Private Banking
717 W. Sprague Avenue
P.O. Box 2127
Spokane, WA 99210-2127

This Plan is a group health plan that is funded using a voluntary employees' beneficiary association under Internal Revenue Code 501(c)(9). The Plan number is 501.

The Plan administration is conducted by a third party, Rehn & Associates, P.O. Box 5433, Spokane, WA 99205-0433, 1-800-VEBA101 (832-2101) or (509) 534-0600.

The Plan consultant is Gallagher VEBA, a Division of Gallagher Benefit Services, Inc., 906 West 2nd Avenue, Suite 400, Spokane, WA 99201, Attn: Mark R. Wilkerson.

The Plan's agent for service of legal process is the City of Burbank Attorney's Office. Notice of legal process may also be delivered to the Trustee or the third-party administration (TPA) service provider.

This Plan is provided under collective bargaining agreements or employer policy. You can obtain copies of applicable agreements or policies by contacting the City of Burbank.

Because the benefits for a participant in the Plan depend solely on the value of the employer's contribution to the Plan on the participant's behalf, the law does not require this Plan to be insured by the Pension Benefit Guaranty Corporation.

All accounts are 100% vested and the Plan does not discriminate regarding eligibility to participate.

In the event any Participant Account shall have been unclaimed for a period of at least three (3) years since the whereabouts or continued existence of the person entitled thereto was last known to the TPA service provider, and the Administrator determines that the whereabouts or continued existence of such person cannot reasonably be ascertained, the remaining balance in such Participant Account shall be forfeited and redistributed per capita to all remaining participant accounts.

The Plan year is the 12-month period – July 1 through June 30.

Requests for benefits under the Plan must be made in writing to the VEBA TPA service provider in accordance with the claims procedure. Requests for benefits that are denied may be appealed in writing to the VEBA TPA service provider. No benefit payable at any time under the Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment or encumbrance of any kind.

PART III

Procedure for Disputed Claims

If your claim is denied in whole or in part, the TPA service provider shall notify you of the denial. Such notice will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman. A statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the TPA service provider. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim request to the TPA service provider.

After the TPA service provider receives an appeal of a denied claim from you or your authorized representative, the TPA service provider shall deliver the complete file to the City, who shall consider your appeal within 30 days from the time that your appeal was received by the TPA service provider.

In special circumstances, the City may request a 15-day extension to review the decision prior to the expiration of the initial 30-day period. The City's decision shall be furnished to you and will include the specific reasons for the denial and sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The notice will also include the specific Plan provisions or IRS rules or regulations upon which the denial is based; a description of any material necessary for your claim to be processed; a description of available internal appeals processes, including information regarding how to initiate an appeal; and the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman. A statement describing the availability, upon request, of the diagnosis code, the treatment code, and the corresponding meanings of these codes will also be included.

The City may determine that a hearing is required to properly consider a claim that has been appealed. In that event, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is appealed. After exhausting the above claims procedures in full, if your request for benefits is denied in whole or in part, you or your authorized representative may request an external review of your denied claim. Any such request for review must be delivered to the TPA service provider no later than four (4) months from the date you received written notification of the City's final denial of your request for benefits or from the date the claim was deemed denied. Within five (5) business days of receiving the external review request, the TPA service provider will complete a preliminary review to confirm that you are covered under the Plan, you provided all the information and forms necessary to process the external review, and have exhausted the internal appeals process.

Once the review above is complete, the TPA service provider will notify you in writing of the outcome of its review. If you are not eligible for external review, the notice will inform you of this and include contact information for the Department of Health and Human Services Health Insurance Assistance Team (HIAT). If your request for external review was incomplete, the notice will describe materials needed to complete the request and you will have the later of 48 hours or the four month filing period to provide the materials needed to complete your filing.

Upon satisfaction of the above requirements, the TPA service provider will assign an independent review organization (IRO) using a method of assignment that assures the independence and impartiality of the assignment process. You may submit to the IRO in writing additional information to consider when conducting the external review, and the IRO must forward any additional information submitted by you to the TPA service provider within one (1) business day of receipt. The decision by the IRO is binding on the Plan, as well as on you, except to the extent other remedies are available under State or Federal law. For standard external review, the IRO must provide written notice to the TPA service provider and to you of its decision to uphold or reverse the benefit denial within no more than forty-five (45) days.

Claims proceedings set forth in the Plan Summary and in more detail in the Plan Document must be strictly adhered to by each claimant and no judicial or arbitration proceedings with respect to any claim for Plan benefits shall be commenced by any such claimant until the appeal has been exhausted in full.

Overpayments or Errors

If it is determined that you and/or your spouse or dependents received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the Plan. If you do not refund the overpayment or erroneous payment, the Plan and TPA service provider reserve the right to offset future reimbursement(s) equal to the overpayment or erroneous payment.

PART IV

Investment Fund Information

INVESTMENT RISK

Accounts invested in stock or bond funds are not guaranteed and will fluctuate in value on a monthly basis. Benefit withdrawals from these types of funds may be worth more or less than your original deposit.

Periodically review your selected investment fund choice(s). Should your objectives change, you should reevaluate your fund selection(s) and notify the TPA service provider in writing of any changes using a VEBA HRA Account Change form. Remember, there have been numerous loss periods in the past in these types of funds and there will be others in the future. Please remember that investment returns, particularly over shorter time horizons, are highly dependent on trends in various investment markets. Thus, stock or bond investments are suitable primarily as longer-term investments and should not be for short-term use.

TRANSFERS

You may transfer among the funds up to once per calendar month. Transfers are effective the first business day of each month. The VEBA TPA service provider must receive transfer requests in writing by the 25th of each month in order to be effective on the first business day of the following month.

WITHDRAWALS

If you have multiple funds, benefit withdrawals made from your account will be deducted pro rata based on your account balance in each fund unless you request otherwise in writing.

USING MULTIPLE FUNDS

You may have your VEBA HRA allocated to a single fund, two funds, three funds, four funds, or to all five funds.

INVESTMENT FUNDS

Vanguard Short-Term Bond Index Fund
Vanguard Total Bond Market Index Fund
Janus Balanced Fund
Vanguard Institutional Index Fund (S & P 500)
Sit Small Cap Growth Fund

ADDITIONAL INFORMATION

You may view additional information regarding the funds (including performance, risk, holdings, management, fund prospectuses, etc.) on the internet at:

Vanguard Short-Term Bond Index Fund
vanguard.com
Vanguard Total Bond Market Index Fund
vanguard.com
Janus Balanced Fund
janus.com

Vanguard Institutional Index Fund (S & P 500)
vanguard.com
Sit Small Cap Growth Fund
sitfunds.com

INVESTMENT ADVICE
Participants are encouraged to seek advice regarding these investment funds from their personal financial advisor. The City of Burbank, Trustee, Plan Consultant, and TPA service provider do not give investment advice.

INVESTMENT EXPENSES
These expenses are expressed as a percent of assets on an annualized basis and are deducted from investment earnings, or if there are no earnings, from participant account balances.

PART V

COBRA Notice, USERRA Rights, and FMLA Notice

COBRA Notice

Important information regarding continuation coverage rights under COBRA for all participants, their spouse and children.

Introduction
The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that provides participants and those covered by this Plan the right to continue to make contributions and/or file claims for a specified time period if such rights are lost due to certain qualifying events.

You, your spouse, and covered children should carefully read this notice. It is intended to generally explain your COBRA continuation coverage rights and the responsibilities of you and your employer as described by the law. This notice is a summary only. It is not an exhaustive description.

Questions regarding your COBRA continuation coverage rights and responsibilities should be directed to the third-party administration (TPA) service provider, Rehn & Associates.

General Information
A "qualifying event" is an event resulting in the loss of continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan.

Individuals losing coverage due to a qualifying event are known as "qualified beneficiaries." Qualified beneficiaries have a right to elect COBRA continuation coverage; however, either the employer or participant is required to notify the TPA service provider within certain time limits for COBRA continuation coverage rights to apply.

COBRA continuation coverage must begin on the day coverage would otherwise end; no lapse in coverage is permitted. Qualified beneficiaries electing COBRA continuation coverage must pay a monthly premium for such coverage. In addition, an administrative fee of 2% is added as permitted by COBRA law.

Qualifying events
***Participating employee*.** If you are a participating employee, you will become a qualified beneficiary if continued employer contributions to the Plan are lost due to any of the following qualifying events: (1) you are voluntarily or involuntarily terminated (other than for gross misconduct; or (2) you experience a reduction in hours affecting eligibility.

Spouse. If you are the spouse of a participating employee, you will become a qualified beneficiary if continued employer contributions and/or access to benefits to which you would have otherwise been entitled under the Plan are lost due to any of the following qualifying events: (1) employee is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) you become divorced or legally separated from employee; or (4) employee passes away.

Children. Children of a participating employee will become qualified beneficiaries if continued employer contributions and/or access to benefits to which they would have otherwise
been entitled under the Plan are lost due to any of the following qualifying events: (1) employee

is voluntarily or involuntarily terminated (other than for gross misconduct); (2) employee experiences a reduction of hours affecting eligibility; (3) employee and spouse become divorced or legally separated; (4) dependent child reaches age limitation or no longer meets definition of a qualifying child; or (5) employee passes away.

***Qualifying event n*otification**
The TPA service provider will offer COBRA continuation coverage to qualified beneficiaries after being notified within allowable time limits.

When the qualifying event is due to an active participating employee's (1) voluntary or involuntary termination (other than for gross misconduct); (2) reduction of hours of employment affecting eligibility; or (3) death, the employer must notify the TPA service provider within 30 days of the occurrence of such event.

All other qualifying events (divorce or legal separation, or child reaches age limitation or no longer meets the definition of qualifying child) require that the participating employee or qualified beneficiary notify the TPA service provider within 60 days of the occurrence of such event, using the Notice of COBRA Qualifying Event form. The completed Notice must be mailed or hand delivered to the TPA service provider. A divorce decree or decree of legal separation is required if the COBRA qualifying event is due to divorce or legal separation; additional documentation may be required. If the Notice is received late, incomplete, or is not submitted as outlined under Notification of Procedures provided on the reverse side of the aforementioned form, no qualified beneficiary will be offered the opportunity to elect COBRA coverage.

COBRA continuation period
The "COBRA continuation period" is the maximum period of time during which a qualified beneficiary may continue coverage under COBRA.

COBRA continuation coverage can last for up to 18 months when the qualifying event is due to a participating employee's: (1) voluntary or involuntary termination (other than for gross misconduct); or (2) reduction of hours of employment affecting eligibility.

A maximum of up to 36 months is allowed when the qualifying event is due to the participating employee's: (1) legal separation or divorce; (2) death; or (3) when a child reaches age limitation or no longer meets the definition of qualifying child.

18-month COBRA continuation period extension
If you or any other family member covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of an 18-month COBRA continuation period, an 11-month extension, for a total of up to 29 months, is allowable for all covered individuals. To receive the extension, you or the qualified beneficiary(ies) must notify the TPA service provider within 60 days of the disability determination and before the end of the original 18-month COBRA continuation period.

Also, if a second qualifying event occurs during an 18-month COBRA continuation period involving the participating employee's legal separation or divorce, or child reaches age limitation (no longer meets the definition of qualifying child), or death, the covered spouse and/or covered children may continue coverage for up to the number of months totaling a maximum 36-month COBRA continuation period. To be eligible for the extension, the qualified beneficiary(ies) must notify the TPA service provider within 60 days of the occurrence of the second qualifying event.

Information resources
Questions concerning your COBRA continuation coverage under this Plan (including the cost of such coverage and when payments are due) should be directed to the TPA service provider, or you may visit www.dol.gov/ebsa to view more information or locate a U.S. Department of Labor Employee Benefits Security Administration (EBSA) office near you.

USERRA RIGHTS

If you are on military leave that is governed by the Uniformed Services Employment and Re-

employment Rights Act (USERRA), you may continue to file claims for qualified expenses for you and your qualified dependents.

If you were entitled to receive a future contribution, but will not receive the contribution due to the military leave, you or your covered qualified dependents may elect to continue contributions to the Plan for the lesser of 24 months or the period ending on the date in which you could, but fail to apply for or return a position of employment with your participating employer. If you make this election, you will generally be required to pay 102% of the contributions to which you were entitled.

Should you have any questions regarding USERRA rights, please contact the TPA service provider.

FMLA NOTICE

The City of Burbank VEBA HRA plan qualifies as a group health plan under the Family and Medical Leave Act (FMLA). If you are receiving monthly or other recurring contributions to your VEBA HRA account, you may be entitled to continued contributions paid by your employer should you go out on FMLA leave.

For additional information regarding FMLA, contact your benefits/payroll office or the Wage and Hour Division of the U.S. Department of Labor at 1-866-4US-WAGE (1-866-487-9243) or visit www.wagehour.dol.gov.

PART VI

NOTICE OF PRIVACY PRACTICES

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.

The City of Burbank sponsors various health and welfare benefit plans, including the following:

- Retiree Health Savings Plan ("RHS")
- Burbank Employee Retiree Medical Trust ("BERMT")
- Utility Retiree Medical Trust ("URMT")
- Post-Employment Health Plan ("PEHP")
- City of Burbank Welfare Benefit Plan ("VEBA")
- Cafeteria Medical Allowance Plan
- City of Burbank Wellness Program
- City of Burbank Sick Leave Conversion Program

The foregoing plans are collectively referred to herein as the "Plan." The Plan is required by law to maintain the privacy of protected health information ("PHI") maintained by the Plan. The Plan must provide participants with notice of its legal duties and privacy practices with respect to PHI under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended and the privacy and security standards issued thereunder (together, the "Privacy Rule"), and any other more stringent state laws.

This Notice of Privacy Practices ("Notice") describes the Plan's privacy practices regarding PHI. Your personal doctor or any other health care provider may have different policies or notices regarding the use and disclosure of the PHI they create or receive. This Notice applies only to the health care components of the Plan, and only to the extent that one or more such components are subject to the Privacy Rule, and does not apply to other benefit plans sponsored by the City of Burbank, such as disability or life insurance.

This Notice describes how the Plan may use and disclose PHI about you in administering your benefits, and it explains your legal rights regarding the PHI.

This Notice is effective September 23, 2013.

How the Plan Uses and Discloses PHI

The term "PHI" means any information, including genetic information, created or received by the Plan that identifies you and relates to your past, present or future physical or mental health or condition, the provision of health care to you, or the past, present, or future payment for the provision of health care to you. In order to administer the Plan, the Plan

may need or receive PHI about you. The Plan obtains that information from many different sources. In administering your Plan benefits, the Plan may use and disclose PHI in various ways, including those described below.

Uses and Disclosures without Authorization
The Plan may use or disclose PHI relating to health care for Plan operations, payment functions, treatment, and under certain other circumstances without your authorization.

Plan Operations
The Plan may use and disclose PHI during the course of plan administration - that is, during operational activities such as quality assessment and improvement; performance measurement and outcomes assessment; enrollment and underwriting (except the Plan cannot use genetic information for underwriting purposes); preventive health, disease management, case management and care coordination; medical review, legal services, and auditing; business planning and development; and business management and general administrative activities. For example, the Plan may use PHI in the administration of detection and investigation of fraud and other general administrative activities, including data and information systems management and participant service.

Payment
To help pay for your Plan benefits, the Plan may use and disclose PHI in a number of ways, including conducting utilization and medical necessity reviews; coordinating care; determining eligibility; and responding to complaints, claims, and appeals. For example, the Plan may use your medical history and other PHI about you to decide what the payment should be — and during the process; the Plan may disclose PHI to your provider. The Plan may also mail information to the address we have on record for the subscriber *(i.e.,* the eligible employee). The Plan may also disclose your PHI to another health plan or a health care provider for its payment activities.

Treatment
The Plan may disclose PHI to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you, including for the coordination or management of your health care by a health care provider and a third party. For example, doctors may request PHI from the Plan to supplement their own records. The Plan may send certain information to doctors for patient safety or other treatment-related reasons. The Plan may also use PHI to contact you regarding other health-related benefits and services.

Disclosure to Business Associates
The Plan contracts with individuals and entities (Business Associates) to perform various functions on the Plan's behalf or to provide certain types of services. To perform these functions or provide these services, the Plan's Business Associates will create, receive, maintain, or transmit PHI. The Plan requires its Business Associates to agree in writing to safeguard your information to the same extent as the Plan, consistent with federal law.

Disclosures to the Plan Sponsor
Without your authorization, the Plan may disclose PHI to the City of Burbank, or another employer participating in the Plan, as Plan Sponsor, but only for the purposes of plan administrative functions performed by the Plan Sponsor on behalf of the Plan. The Plan Sponsor may not use such **PHI** for any other purpose and is required to safeguard the privacy of your PHI. In addition, the Plan may provide summary health information to the Plan Sponsor so that the Plan Sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Plan also may disclose to the Plan Sponsor information on whether you are participating in the Plan. The Plan Sponsor cannot use your PHI obtained from the Plan for any employment-related actions without your authorization. However, health information derived from other sources, such as those in connection with an application for disability benefits or a leave under the Family Medical Leave Act, is not protected by HIPAA.

Disclosure to Others Involved in Your Health Care
The Plan may disclose PHI about you to a relative, a friend, the subscriber to the Plan or any person you identify, provided the PHI is directly relevant to that person's involvement with your health care. For example, if a family

member or a caregiver calls the Plan with prior knowledge of a claim, the Plan may confirm whether or not the claim has been received and paid. You have the right to stop or limit this kind of disclosure by contacting the Plan's Privacy Official.

After your death, the Plan may disclose relevant PHI to a family member, relative, or close friend who was involved in your health care or payment for health care prior to your death, unless doing so would go against your prior expressed preference.

Additional Reasons for Disclosure without Authorization

Without your authorization, the Plan may use or disclose PHI for the following reasons:

- **Required by Law —** as necessary to comply with federal, state, or local law.
- **Public Health Activities —** for certain public health activities, such as to a public health authority to prevent or control disease, or to a school related to proof of immunization required by law.
- **Victims of Abuse, Neglect, or Domestic Violence —** if the Plan reasonably believes you are a victim of abuse, neglect, or domestic violence. You will be informed if such a disclosure has been made, unless informing you would place you at risk of serious harm or the Plan would be informing your personal representative who the Plan reasonably believes is responsible for the abuse, neglect, or injury.
- **Health Oversight Activities —** to government agencies responsible for oversight of the health care system or for ensuring compliance with the rules of government benefit programs, such as Medicare or Medicaid, or other regulatory programs that need PHI to determine compliance, state insurance departments, U.S. Department of Labor and other government agencies.
- **Judicial and Administrative Proceedings —** in response to a court order or other lawful process.
- **Law Enforcement —** to federal, state and local law enforcement officials for law enforcement purposes, such as in an emergency to report a crime.
- **Your Death —** upon your death, the Plan may release your PHI to a coroner or medical examiner for purposes of identifying you or determining a cause of death, and to funeral directors as necessary to carry out their duties. The Plan may also release your PHI to the executor or administrator of your estate. Your PHI is no longer protected after you have been deceased for more than 50 years.
- **Organ Donors —** to organ procurement organizations or other such entities for the purpose of facilitating donation and transplantation.
- **Research —** to researchers, subject to certain legal restrictions.
- **Serious Threat to Health or Safety —** if the Plan believes in good faith that disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or that of the public.
- **Specialized Government Functions —** related to the military or veterans, national security and intelligence activities, protection for the president, and correctional institutions.
- **Workers' Compensation —** to the extent necessary to comply with laws related to workers' compensation or similar programs.

Uses and Disclosures Requiring Your Written Authorization

In situations other than those described above, the Plan will ask for your written authorization before using or disclosing your PHI. The Plan must obtain your written authorization for any use or disclosure of psychotherapy notes or for marketing and sale purposes. If you have given the Plan an authorization, you may revoke it at any time, if the Plan has not already acted on it. The Plan is unable to take back any disclosures already made with your authorization. If you have questions regarding authorizations, please contact the Plan's Privacy Official.

Your Individual Rights

The Privacy Rule gives you the right to make certain requests regarding PHI about you. You have the following rights regarding your PHI:

Right to Receive Confidential Communications. You may request that the Plan communicate with you in a certain way or at a certain location. Your request must be in writing. The Plan will honor reasonable requests if the communication could endanger you.

- **Right to Request Restrictions.** You may request restrictions on the way the Plan uses or discloses **PHI** about you in connection with Plan operations, payment and treatment. Your request must be in writing. You also have the right to ask the Plan to restrict disclosures to persons involved in your health care. While the Plan will consider reasonable requests, the Plan is not required to agree to your request. However, the Plan must comply with your restriction request when the Plan discloses PHI to a health plan for purposes of payment or health care operations and the PHI pertains solely to a health care item or service for which you, or a person on your behalf (other than the Plan), have already paid in full to the health care provider involved.
- **Right to Inspect and Copy PHI.** You may request that the Plan provide you with access to or a copy of **PHI** that is contained in a "designated record set" - records used in making enrollment, payment, claims adjudication, plan management and other decisions. Your request must be in writing. You may request an electronic copy of your **PHI.** You may also designate another person to receive the copy of your PHI. The Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request for psychotherapy notes, information compiled for a civil, criminal, or administrative proceeding, and under certain other circumstances.
- **Right to Amend PHI.** You may request that the Plan amend PHI that is in a "designated record set." Your request must be in writing and must include the reason for the request. If the Plan denies the request, you may file a written statement of disagreement. If your doctor or another person created the PHI that you want to change, you should ask that person to amend the information.
- **Right to an Accounting.** You may request that the Plan provide a list of certain disclosures the Plan has made about you, such as disclosures of **PHI** to government agencies. The accounting will not include disclosures made for, payment or Plan operations; disclosures made earlier than 6 years before the date of the request; and certain other disclosures excepted by law. Your request must be in writing. If you request such an accounting more than once in a 12-month period, the Plan may charge a reasonable fee. Your written request must be for a stated time period, which may not be longer than six years.

You may make any of the requests described above, or may request a paper copy of this Notice, by contacting the Plan's Privacy Official.

The Plan's Legal Obligations

The Privacy Rule requires the Plan to keep PHI about you private (to the extent provided by the Privacy Rule), to give you notice of its legal duties and privacy practices, to notify you if you are affected by a breach of unsecured PHI, and to follow the terms of the Notice currently in effect. This Notice is provided to you based solely on the Privacy Rule requirements and serves no purpose under the Employee Retirement Income Security Act of 1974 ("ERISA"). Thus, this Notice is not a document governing the Plan under ERISA and you may not bring a private cause of action based on this Notice or the Plan's obligations under the Privacy Rule.

This Notice is Subject to Change

The Plan may change the terms of this Notice and its privacy policies at any time. If the Plan does, the new terms and policies may then be applied to all PHI previously received and then maintained by the Plan, as well as PHI created or received in the future. If the Plan makes any material changes to this Notice, the Plan will

distribute a new notice to its subscribers (i.e., the eligible employees).

Complaints
You have the right to file a complaint if you think your privacy rights have been violated. To do so, please contact the Plan's Privacy Official. You also may submit a complaint to the Secretary of the U.S. Department of Health and Human Services. The Plan will not retaliate against you for making a complaint.

Contact Information
If you have questions, requests or complaints regarding this Notice, please contact the Plan's Privacy Official:

Management Services Director
City of Burbank, Management Services Department
301 E. Olive Ave.
Burbank, CA 91502
p: 818-238-5026

PART VII

Medicare Part D Notice of Noncreditable Coverage

To participants, spouses, children and dependents eligible or becoming eligible for Medicare. Important notice regarding your prescription drug coverage under this Plan and Medicare Part D.

Introduction
Please read this notice carefully and keep it where you can find it. This notice contains information about prescription drug coverage provided by this Plan and Medicare Part D prescription drug coverage available for everyone with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Medicare Part D prescription drug coverage became available in 2006.
You may have heard about Medicare's prescription drug coverage and wondered how it will affect you. Medicare prescription drug coverage became available to everyone with Medicare in 2006. All Medicare Part D prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

You might want to consider enrolling in Medicare prescription drug coverage.
Prescription drug coverage provided by this Plan is limited to your available account balance and is considered "non-creditable." In other words, coverage provided by this Plan is, on average for all Plan participants, NOT expected to pay out as much as the standard Medicare prescription drug coverage will pay. Therefore, you might want to consider enrolling in a Medicare prescription drug plan.

If you don't enroll when first eligible, you may pay more and have to wait to enroll.
Generally, individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. If, after becoming eligible for Medicare, you go 63 days or longer without creditable coverage (prescription drug coverage that is at least as good as Medicare's prescription drug coverage), your premium will go up at least 1% per month for every month that you did not have creditable coverage. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. For example, if you go nineteen months without creditable coverage, your premium will always be at least 19% higher than what many other people pay.

If you or your spouse, children, or dependents are currently Medicare eligible, you need to make a decision.
The terms of this Plan will not change if you choose to enroll in a Medicare prescription drug plan. This Plan will continue to reimburse all qualified premiums and expenses, including prescription drug costs not payable under the Medicare prescription drug plan, subject to the terms of the Plan and limited to your available account balance.

When making your decision whether to enroll, you should compare your current coverage, including which drugs are covered, with the coverage offered by the Medicare prescription drug plans in your area.

Information resources

More detailed information about Medicare plans that offer prescription drug coverage is contained in the Medicare & You handbook from Medicare available online at www.medicare.gov. You may also be contacted directly by Medicare-approved prescription drug plans. Obtain additional information by (1) visiting www.medicare.gov for personalized help; (2) calling your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for telephone numbers); or (3) calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Find out more by visiting the Social Security Administration online at www.socialsecurity.gov, or by calling 1-800-772-1213 (TTY 1-800-325-0778).

NOTE: You might receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage and when necessitated by coverage changes. You may also request a copy at any time from the TPA service provider.

PART VIII

Facts About Premium Tax Credit Eligibility

Introduction

You may qualify for the Premium Tax Credit starting in 2014 if you (or a family member) purchase health insurance through a state or federal marketplace exchange. If you are eligible for the Premium Tax Credit, you can choose to take it in advance, which will lower your current out-of-pocket premium amount, or you can wait until you file your tax return. The Premium Tax Credit subsidizes a portion of the premiums you pay for health insurance purchased through a marketplace exchange. Go to www.irs.gov/uac/The-Premium-Tax-Credit for more information.

If you purchase insurance through a marketplace exchange and want to qualify for the Premium Tax Credit, you should know:

1. **Premiums subsidized by the Premium Tax Credit may not be reimbursed from your VEBA HRA account.** In other words, you cannot use your tax-free VEBA HRA funds to reimburse premiums that are subsidized by the Premium Tax Credit. IRS rules do not permit you to receive two tax advantages on the same expense.
2. **For any month during which you are claims-eligible and retain a positive account balance in your VEBA HRA account, you may not qualify for the Premium Tax Credit for that month unless you take certain action.** If you are claims-eligible and retain a positive VEBA HRA account balance, or receive additional contributions to any VEBA HRA account, then it may make sense for you to use up, limit, or forfeit your VEBA HRA account, as described in more detail below, before taking the Premium Tax Credit in advance.

But first, keep in mind that, depending on your circumstances, you may not need to take any action at all. For example, if any of the following factors are true, then you are not eligible for the Premium Tax Credit and do not need to use up, limit, or forfeit your VEBA HRA account:

- You are eligible for coverage in an employer-sponsored group health plan that meets the affordability and minimum value requirements under federal health care reform law. (If you are not sure whether this applies to you, check with your employer);
- You are eligible for coverage under a governmental plan such as Medicaid, Medicare, CHIP, or TRICARE;
- Your total family income (including income from investments, retirement benefits, and social security) exceeds the maximum amount for eligibility for the

Premium Tax Credit (400% of the federal poverty level);
- You are married but do not file a joint return; or
- You are claimed as a dependent on someone else's tax return.

What can I do if my VEBA HRA account is the only thing keeping me from becoming eligible for the Premium Tax Credit?

If you are claims-eligible and your VEBA HRA coverage is the only reason you cannot qualify for the Premium Tax Credit, you may consider:

1. **Using up your VEBA HRA account before taking the Premium Tax Credit**. You do not have to take the Premium Tax Credit right away. You could first use up your VEBA HRA account to reimburse your non-subsidized premiums (and any other qualified healthcare expenses). Then, you could begin taking the Premium Tax Credit in advance or wait and claim it on your tax return, but only for premiums you paid after using up your VEBA HRA account. Keep in mind that if you receive any additional VEBA HRA contributions after using up your VEBA HRA account, you will lose eligibility for the Premium Tax Credit again for any months during which you retain a positive balance in your VEBA HRA account.

2. **Electing Pre-Medicare Limited-Scope Coverage**. If you make this election, your VEBA HRA account will reimburse only certain dental, vision, and long-term care expenses and premiums (subject to IRS limitations) until you become Medicare-eligible either by age or permanent disability. VEBA HRA Pre-Medicare Limited-Scope qualifies as an "excepted benefits plan" and is not considered "minimum essential coverage" under federal health care reform law. **This election will remain in force with respect to any expenses you incur after the date you make the election and until you turn age 65 (or earlier upon death or Medicare eligibility due to permanent disability), at which time you may convert your VEBA HRA account back to full coverage for all types of qualified medical expenses and premiums.**

   The **Pre-Medicare Limited-Scope Coverage Election Form** is available after logging into your account online at **www.burbank.rehnonline.com** under **Participant Forms** or by request from the third-party administration service provider, Rehn & Associates, at burbank@rehnonline.com or 1-800-832-2101.

3. **Electing to Forfeit Future Reimbursements**. In lieu of electing Pre-Medicare Limited-Scope Coverage, you have the right under the VEBA HRA Plan and under federal health care reform law to permanently forfeit or give up all future reimbursements from any amounts currently held in your VEBA HRA account or that may be contributed into your account prior to or during any period for which you receive the Premium Tax Credit. **This election is permanent and means that you are giving up your account and forfeiting future reimbursements from the VEBA HRA Plan.**

   The **Waiver of Future Reimbursements Election Form** is available after logging into your account online at **www.burbank.rehnonline.com** under **Participant Forms** or by request from the third-party administration service provider, Rehn & Associates, at burbank@rehnonline.com or 1-800-832-2101.

Consider Your Options Carefully

You should consider your options carefully and seek advice from a tax professional. The best decision may vary depending on your unique circumstances, including the amount of your VEBA HRA account balance compared to the amount of your Premium Tax Credit.

For example, if you are eligible for a large Premium Tax Credit and have a small VEBA HRA account balance, you may decide to quickly use up or forfeit your VEBA HRA account balance in order to take advantage of the Premium Tax Credit. But, if you are only eligible for a small Premium Tax Credit and have a larger VEBA HRA account balance (or expect to receive future VEBA HRA contributions), you may decide to either (1) elect Pre-Medicare Limited-Scope Coverage and take the Premium Tax Credit right away or (2) delay taking the Premium Tax Credit and continue to use your VEBA HRA account for all of your out-of-pocket expenses and unsubsidized premiums until it runs out.

Keep in mind that if you take advance Premium Tax Credit payments without first using up, limiting, or forfeiting your VEBA HRA account as described above, you will likely be ineligible for the Premium Tax Credit and may be required to pay it back when you file your tax return for the year.

Where Can I Get More Information?

This section is intended to provide you with general information about the Premium Tax Credit and the options available to you under the VEBA HRA Plan. **More information can be found online at www.irs.gov/uac/The-Premium-Tax-Credit.**

If you have questions, you should contact VEBA HRA's plan consultant, VEBA Service Group, a Division of Gallagher Benefit Services, Inc., at 1-800-888-8322. A client consultant or service representative is available to assist you. The VEBA HRA Plan and its agents, including VEBA Service Group, do not give tax advice.