Article VII — Amendment and Termination

Article I — Title, Establishment, and General Definitions

§ 20A-101 Short Title.

This Chapter shall be known, and may be cited, as the "Borough of Alburtis Health Reimbursement Arrangement for Nonuniformed Employees."

[Ord. 524 12-29-2014]

§ 20A-102 Establishment.

The Borough of Alburtis hereby establishes a Health Reimbursement Arrangement in order to provide certain employees with reimbursements of certain qualifying medical care expenses that are excludable from gross income under Section 105(b) of the Internal Revenue Code of 1986. This Plan is intended to qualify as a health reimbursement arrangement under IRS Notices 2002-45 and 2013-54, and as an accident or health plan within the meaning of Code §§ 105(e) and 106, as they may be amended from time to time, and is to be interpreted in a manner consistent with the requirements of those provisions, so that the benefits provided under this Plan shall be eligible for exclusion from a participating employee's gross income for federal income tax purposes under Code § 105(b). This Plan is offered as a supplement to the Employer's Primary Health Plan, and is integrated with the Primary Health Plan. A Participant must be enrolled in the Primary Health Plan as a condition of participation in this Plan.

[Ord. 524 12-29-2014]

§ 20A-103 Definitions—In General.

For purposes of this Chapter, the terms defined in the remaining Sections of this Article I shall have the meanings indicated therein, whether with or without initial capital letters, unless the context in which they are used clearly indicates a different meaning.

[Ord. 524 12-29-2014]

§ 20A-104 Administrator.

The term "Administrator" shall mean the Plan Administrator described in Article VI.

[Ord. 524 12-29-2014]

§ 20A-105 [RESERVED]

[Ord. 526 01-18-2015]

§ 20A-106 Code.

The term "Code" shall mean the Internal Revenue Code of 1986, as amended (Title 26, U.S. Code). Reference to a section of the Code shall mean that section as it may be amended or renumbered from time to time, or any corresponding provision of any future legislation that amends, supplements or supersedes that section.

[Ord. 524 12-29-2014]

§ 20A-107 Covered Family Member.

The term "Covered Family Member", at any given time, shall mean a Participant's Spouse or Dependent who is covered by this Plan at that time under § 20A-204.

[Ord. 524 12-29-2014]

§ 20A-108 Dependent.

The term "Dependent" means, with respect to any Participant, any individual who is either—

(a) a dependent of the Participant within the meaning of Code § 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), except that any child to whom Code § 152(e) applies (relating to special rule for divorced parents) shall be treated as a "Dependent" of both parents;

(b) a child (as defined in Code § 152(f)(1)) of the Participant who as of the end of the Plan Year has not attained age 27; or

(c) an alternate recipient under a Qualified Medical Child Support Order (as these terms are defined under federal law) with respect to the Participant.

[Ords. 524 12-29-2014, 525 01-14-2015]

§ 20A-109 Effective Date.

The "Effective Date" of this Plan is January 1, 2015.

[Ord. 524 12-29-2014]

§ 20A-110 Employer.

The term "Employer" shall mean the Sponsor, and all Related Employers which have adopted this Plan and executed a copy of this Chapter.

[Ord. 524 12-29-2014]

§ 20A-111 HRA Account.

The term "HRA Account" means, for a Participant for a given Plan Year, the HRA Account established for that Participant for that Plan Year under Article III.

[Ord. 524 12-29-2014]

§ 20A-112 HRA Deductible.

(a) 2015+. For calendar year 2015 and subsequent calendar years, the term "HRA Deductible (Individual)" shall mean Three Hundred Dollars ($300.00), and the term "HRA Deductible (Family)" shall mean Six Hundred Dollars ($600.00).

[Ords. 524 12-29-2014, 543 12-27-2017]

§ 20A-113 Maximum Coverage Amount.

(a) 2015+. For calendar year 2015 and subsequent calendar years, the term "Maximum Coverage Amount (Individual)" shall mean Two Thousand Dollars ($2,000.00), and the term "Maximum Coverage Amount (Family)" shall mean Four Thousand Dollars ($4,000.00).

[Ords. 524 12-29-2014, 543 12-27-2017]

§ 20A-114 Participant.

The term "Participant" shall mean any person who participates in this Plan in accordance with Article II.

[Ord. 524 12-29-2014]

§ 20A-115 Period of Coverage.

The term "Period of Coverage" shall mean the Plan Year, except that for a person who is not a Participant during the entire Plan Year, the "Period of Coverage" shall mean the portion of the Plan Year that the person is a Participant.

[Ord. 524 12-29-2014]

§ 20A-116 Plan.

The term "Plan" shall mean the **Borough of Alburtis Health Reimbursement Arrangement for Nonuniformed Employees**, as set forth in this Chapter, and as it may be amended from time to time.

[Ord. 524 12-29-2014]

§ 20A-117 Plan Year.

The term "Plan Year" shall mean any 12 consecutive month period beginning on January 1 and ending on the following December 31.

[Ord. 524 12-29-2014]

§ 20A-118 Primary Health Plan.

The term "Primary Health Plan" shall mean the health/medical/ hospitalization coverage plan provided from time to time under § 12-403 (relating to Personnel Policies—Benefits—Health & Hospitalization). As of January 1, 2015, the Primary Health Plan is the product known as Healthy Benefits PPO 2000 . 0 PD . Rx $0, as offered to the Borough of Alburtis and renamed from time to time by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross which takes over that product), but the specific plan and/or the coverages available under the plan may change from time to time.

[Ord. 524 12-29-2014]

§ 20A-119 [RESERVED]

[Ord. 524 12-29-2014]

§ 20A-120 Qualified Employee.

The term "Qualified Employee" shall mean, as of any given date, any person who is receiving remuneration for personal services rendered to the Employer (other than as an independent contractor) and whose customary employment is at least thirty-five (35) hours per week (including permitted paid time off), *provided* such person is neither—

(a) a nonresident alien who receives no remuneration from the Employer which constitutes income from sources within the United States (within the meaning of the Code);

(b) a person who is included in a unit of employees covered by a negotiated collective bargaining agreement which does not expressly provide for his/her inclusion as a person eligible for participation in this Plan;

(c) a person who is employed as a police officer (including the Chief of Police);

(d) a temporary employee expected to be employed for no more than six (6) months;

(e) a leased employee within the meaning of Code § 414(n) or § 414(o) who is not a common law employee of the Employer; *nor*

(f) a self-employed individual within the meaning of Code § 401(c).

[Ord. 524 12-29-2014]

§ 20A-121 Qualifying Medical Care Expenses.

(a) In General. Except as provided otherwise in this § 20A-121, the term "Qualifying Medical Care Expenses" means expenses incurred by a Participant or his/her Covered Family Member, for Medical Care of the Participant during the time he/she is a Participant or for Medical Care of a Participant's Covered Family Member during the time he/she is a Covered Family Member, and which are applied to a deductible under the Primary Health Plan. Qualifying Medical Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(b) Medical Care. For purposes of this § 20A-121, the term "Medical Care" shall mean amounts paid (within the meaning of Code § 213(d) and the regulations and rulings thereunder):

(1) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including medicine and drugs purchased without a physician's prescription, but not dietary supplements that are merely beneficial to general health, *see* Rev. Rul. 2003-102);

(2) for transportation primarily for and essential to medical care referred to in paragraph (1); *or*

(3) amounts paid for lodging (not lavish or extravagant under the circumstances, and not more than $50 per night per individual) while away from home primarily for and essential to medical care referred to in paragraph (1) if the medical care referred to in paragraph (1) is provided by a physician (as defined in section 1861(r) of the Social Security Act, 42 U.S.C. § 1395x(r)) in a licensed hospital (or in a medical care facility which is related to, or the equivalent

of, a licensed hospital), and there is no significant element of personal pleasure, recreation, or vacation in the travel away from home.

(c) Exceptions. Notwithstanding anything to the contrary in this section, "Qualifying Medical Care Expenses" shall *not* include—

(1) any expenses to the extent that the Participant or other person incurring them is reimbursed or entitled to reimbursement for the expense through insurance or otherwise (other than under this Plan), *except* that this restriction shall not apply to any reimbursements under Chapter 20 (relating to Medical Expense Reimbursement Plan) used to reimburse expenses which are not reimbursable by this Plan by virtue of § 20A-405 (relating to HRA Deductibles); *or*

(2) any premium paid for other health coverage, including but not limited to employee contributions toward the coverage provided under a health/medical/hospitalization plan of the Employer, such as the payments required under § 12-403(c)(2), (3) (relating to Personal Policies—Benefits—Health & Hospitalization—Employee Contributions to Premiums) or corresponding provisions of a collective bargaining agreement.

[Ords. 524 12-29-2014, **525** 01-14-2015**]**

§ 20A-122 Related Employee.

The term "Related Employer" shall mean any—

(a) corporation which is a member of a controlled group of corporations (as defined in Code § 414(b)) which includes the Sponsor;

(b) trade or business (whether or not incorporated) which is under common control (as defined in Code § 414(c)) with the Sponsor;

(c) member of an affiliated service group (as defined in Code § 414(m)) which includes the Sponsor; and

(d) any other entity required to be aggregated with the Sponsor pursuant to Code § 414(o) and the regulations thereunder.

[Ord. 524 12-29-2014**]**

§ 20A-123 Sponsor.

The term "Sponsor" shall mean the **Borough of Alburtis**, Lehigh County, Pennsylvania, a Pennsylvania borough and municipal corporation, and its predecessors and successors.

[Ord. 524 12-29-2014**]**

§ 20A-124 Spouse.

The term "Spouse" shall mean a person recognized as the spouse of a Participant under the rules established or or recognized by the Internal Revenue Service.

[Ord. 524 12-29-2014]

Article II — Participation

§ 20A-201 Commencement of Participation.

Every Qualified Employee shall become eligible to participate in this Plan on the *later* (a) the Effective Date, or (b) the date he/she becomes enrolled in and covered by the Primary Health Plan.

[Ord. 524 12-29-2014]

§ 20A-202 Cessation of Participation.

(a) In General. Except as otherwise provided in this § 20A-202, a Participant will cease to be a Participant as of the *earlier* of (1) the date he/she ceases to be a Qualified Employee, or (2) the date he/she ceases to be covered by the Primary Health Plan.

(b) Termination of Plan. A Participant will cease to be a Participant in this Plan no later than the date as of which this Plan is terminated.

(c) Expenses Incurred Prior to Cessation of Participation. Notwithstanding anything to the contrary contained in this Section, a former Participant remains entitled to benefits under this Plan with respect to Qualifying Medical Care Expenses incurred prior to the cessation of his/her participation, under the same terms, conditions, and procedures applicable to Participants.

[Ord. 524 12-29-2014]

§ 20A-203 Reinstatement of Former Participant.

A former Participant may become a Participant in this Plan again in accordance with the provisions of § 20A-201.

[Ord. 524 12-29-2014]

§ 20A-204 Covered Family Members.

A Spouse or Dependent of a Participant shall be a Covered Family Member for such period of time as the Spouse or Dependent is covered under the Primary Health Plan as a spouse or dependent of the Participant, and the Participant is a Participant under this Plan.

[Ord. 524 12-29-2014]

§ 20A-205 Waiver of Coverage.

(a) Annual Option. A Qualified Employee may permanently opt-out of and waive coverage under this Plan in any December, effective on the immediately following January 1. If the Qualified Employee had been a Participant, he/she shall cease to be a Participant on that January 1.

(b) Termination of Employment. Upon termination of employment, if any remaining amounts in a Participant's HRA Account are not forfeited under the terms of this Plan, the Participant may permanently opt out of and waive future reimbursements from this Plan for expenses incurred after the date of the termination.

[Ord. 524 12-29-2014]

§ 20A-206 Continuation of Coverage.

(a) COBRA. The Employer is not obligated to provide federal COBRA continuation coverage under this Plan because it normally employs fewer than twenty employees. 42 U.S.C. § 300bb-1(b)(1); 29 U.S.C. § 1161(b); Treas. Regs. § 54.4980B-2 (Q&A 5). However, if the number of employees should increase or the legal requirements change such that the federal COBRA continuation coverage rules do apply to this Plan, this Plan shall provide such coverage to the extent required by law and elected by the qualified beneficiaries, subject to the payment of monthly premiums in an amount described in subsection (d).

(b) Pennsylvania Mini-COBRA. The Employer is also not obligated to provide the shorter-duration Pennsylvania mini-COBRA continuation coverage under this Plan because it is a self-insured plan and not group policy issued by an "insurer". 40 PA. STAT. ANN. § 764j(g)(4), (5). However, if the legal requirements change such that the Pennsylvania mini-COBRA continuation coverage rules do apply to this Plan, this Plan shall provide such coverage to the extent required by law and elected by the covered employee and/or eligible dependent, subject to the payment of monthly premiums in an amount described in subsection (d).

(c) Combination with Continuation Coverage Under the Primary Health Plan. If a person would be eligible for continuation coverage under this Section, that person may only elect such continuation coverage if he/she also elects continuation coverage under the Primary Health Plan. Thus, such a person could elect contination coverage under the Primary Health Plan alone, or under both this Plan and the Primary Health Plan, but not under this Plan alone.

(d) Premiums.

(1) In General. The amount of the monthly premium to be paid by each qualified beneficiary for continution coverage under this Plan for any month in a given calendar year shall be equal to one hundred two percent (102%) of the Maximum Coverage Amount (Individual) for that calendar year, divided by twelve (12), and multiplied by the Applicable Percentage for that calendar year as described below.

(2) 2015. The Applicable Percentage for calendar year 2015 shall be twenty-five percent (25%).

(3) Other Years. The Applicable Percentage for calendar years after 2015 shall be determined as of December 31 of the preceding year, and shall be the percentage equivalent of the fraction whose numerator is the total amount of reimbursements paid by the Plan for expenses incurred during the preceding year, and whose denominator is equal to the total of:

(A) the number of Participants participating in the Plan during the preceding year who did not have spouse or dependent coverage under the Plan, multiplied by the Maximum Coverage Amount (Individual) for the preceding year; and

(B) the number of Participants participating in the Plan during the preceding year who had spouse and/or dependent coverage under the Plan, multiplied by the Maximum Coverage Amount (Family) for the preceding year.

[Ord. 524 12-29-2014**]**

Article III — HRA Accounts

§ 20A-301 Establishment of Accounts; Contributions and Funding.

The Employer will establish and maintain on its books an HRA Account for each Plan Year with respect to each person who is a Participant in the Plan at any time during the Plan Year. The Employer does not maintain actual, separate, and discrete accounts for Participants under this Plan. All payments under this Plan shall be made from the general assets of the Employer, and no assets shall be earmarked or segregated for purposes of providing benefits under this Plan. The HRA Accounts are strictly bookkeeping records. All amounts credited to an HRA Account shall be and remain the property of the Employer until paid out pursuant to this Plan.

[Ord. 524 12-29-2014**]**

§ 20A-302 Crediting of Accounts.

(a) In General. As of the first day of each Plan Year or, if later, the first day in a Plan Year that a Participant becomes a Participant in this Plan, the HRA Account for that Plan Year of each Participant who has no Covered Family Members shall be credited with an amount equal to the Maximum Coverage Amount (Individual) for such Plan Year, and the HRA Account for that Plan Year of each Participant who has one or more Covered Family Members shall be credited with an amount equal to the Maximum Coverage Amount (Family) for such Plan Year.

(b) Mid-Year Family Coverage. If a Participant whose HRA Account for a Plan Year was initially credited with the Maximum Coverage Amount (Individual) under subsection (a) should, at any time during the Plan Year, have a Covered Family Member, then the HRA Account of the Participant for that Plan Year shall be credited with an increase equal to the difference between the Maximum Coverage Amount (Family) for that Plan Year and the Maximum Coverage Amount (Individual) for that Plan Year.

[Ord. 524 12-29-2014**]**

§ 20A-303 Debiting of Accounts.

A Participant's HRA Account for a given Plan Year shall be debited from time to time in the amount of any payment under Article IV to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during such Plan Year.

[Ord. 524 12-29-2014**]**

§ 20A-304 Forfeiture of Accounts.

(a) Unused Balance for Plan Year. If any balance remains in a Participant's HRA Account for any Plan Year after all permissible reimbursements under this Plan—

(1) such balance shall *not* be carried over to reimburse the Participant for any Qualifying Medical Care Expenses incurred during a subsequent Plan Year;

(2) such balance shall not be available to the Participant in any other form or manner;

(3) the Participant shall forfeit all rights with respect to such balance; *and*

(4) such balance shall remain the property of the Employer.

(b) Termination of Employment. As provided in § 20A-202, following a termination of employment, all rights of a Participant to receive reimbursement of Qualifying Medical Care Expenses incurred after the date of termination are forfeited.

[Ord. 524 12-29-2014**]**

Article IV — Benefits

§ 20A-401 Claims for Reimbursement.

Subject to the procedures and limitations set forth in this Article IV and in Article V, a person who is a Participant in any given Plan Year shall be entitled to receive reimbursement of Qualifying Medical Care Expenses which are incurred during that Plan Year and submitted to the Plan for reimbursement during that Plan Year or within three (3) months after the close of that Plan Year. An expense is incurred on the date services are rendered, regardless of when the services are billed or paid.

[Ord. 524 12-29-2014]

§ 20A-402 Application for Reimbursement.

(a) Application Form. All applications for reimbursement of Qualifying Medical Care Expenses under this Plan shall be filed with the Administrator on such forms as the Administrator may require. Each application shall include, with respect to each expense for which reimbursement is requested:

(1) the amount and nature of the expense;

(2) the name and address of the person, organization, or entity to which the expense was paid;

(3) the date(s) on which the services covered by the expense were provided;

(4) the name of the person for whom the expense was incurred, together with an identification of that person as the Participant or a Covered Family Member;

(5) the amount recovered or expected to be recovered with respect to the expense under any insurance arrangement or other plan;

(6) a statement that the expense (or the portion thereof for which reimbursement is sought under this Plan) has not been reimbursed and is not reimbursable under any insurance or other health plan coverage (other than this Plan); *and*

(7) such other information as the Administrator may, from time to time, require.

(b) Required Documentation. All applications for reimbursement of Qualifying Medical Care Expenses under this Plan shall be accompanied by the following documents for each expense for which reimbursement is requested:

(1) a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense (such as an explanation of benefits or a provider's invoice); *and*

(2) such other bills, invoices, receipts, cancelled checks, or other statements or documents which the Administrator may request to prove that a Qualifying Medical Care Expense has been incurred.

(c) Time of Application.

(1) Earliest Submission of Reimbursement Applications. An application for reimbursement of Qualifying Medical Care Expenses under this Plan may not be filed until after all services covered by the application have been rendered, and until after the Qualifying Medical Care Expenses have first been submitted to and adjudicated by the claims administrator of the Primary Health Plan.

(2) Latest Submission of Reimbursement Applications. All applications for reimbursement of Qualifying Medical Care Expenses for services rendered during any given Plan Year shall be submitted no later than three (3) calendar months after the end of the Plan Year.

[Ords. 524 12-29-2014, **526** 01-18-2015**]**

§ 20A-403 Time of Reimbursement.

Reimbursements under this Plan shall be made at such time and in such manner as the Administrator may prescribe. The Administrator need not make any particular reimbursement until an administratively reasonable period after a Participant submits an appropriate application and documentation under § 20A-402. Payments shall not require final approval by Borough Council, and shall not be delayed based on the meeting schedule of Borough Council.

[Ords. 524 12-29-2014, **547** 07-25-2018**]**

§ 20A-404 Limitation Based on Amount in Participant's HRA Account.

No reimbursement under this Article IV of Qualifying Medical Care Expenses incurred during a Plan Year shall at any time exceed the balance of the Participant's HRA Account for the Plan Year at the time of the reimbursement.

[Ord. 524 12-29-2014**]**

§ 20A-405 HRA Deductibles.

(a) Individual Deductible. Notwithstanding anything to the contrary contained in this Plan (except as provided in this Section), this Plan shall *only* provide reimbursements for the Qualifying Medical Care Expenses incurred in a Plan Year for medical care for any given Participant or Covered Family Member which are in *excess* of the HRA Deductible (Individual) for that Plan Year.

(b) Family Deductible. Notwithstanding subsection (a), if the total Qualifying Medical Care Expenses incurred in a Plan Year for medical care for a Participant and all the Participant's Covered Family Members exceeds the HRA Deductible (Family) for that Plan Year, the excess amount shall be reimbursable by this Plan (subject to the procedures and limitations of this Chapter other than subsection (a)).

[Ords. 524 12-29-2014, **525** 01-14-2015**]**

§ 20A-406 Death of a Participant.

In the event of the Participant's death, the Participant's surviving Spouse (or, if none, the Participant's personal representative) may apply on the Participant's behalf for reimbursements permitted under this Article IV.

[Ord. 524 12-29-2014**]**

§ 20A-407 Responsibility for Payment.

It is the Participant's (and/or Covered Family Member's) responsibility to pay for all Qualifying Medical Care Expenses. Any payments under this Plan made directly to a Participant or the Participant's representative for Qualifying Medical Care Expenses shall completely discharge all liability of this Plan, the Administrator, and the Employer with respect to such expenses.

[Ord. 524 12-29-2014**]**

§ 20A-408 Overpayments.

If, for any reason, any benefit under this Plan is erroneously paid or exceeds the amount payable on account of a Participant's Qualifying Medical Care Expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Plan, a deduction from compensation otherwise payable by the Employer to the Participant, or any other method which the Administrator, in its discretion, may require.

[Ord. 524 12-29-2014**]**

§ 20A-409 Fraudulent Claims.

If any person is found to have falsified any document in support of a claim for benefits or coverage under this Plan, the Employer may, without anyone's consent, terminate that person's coverage under this Plan without any right to future reinstatement, and the Administrator may refuse to honor any claims by such person under this Plan..

[Ords. 524 12-29-2014, **526** 01-18-2015**]**

Article V — Claims Procedure

§ 20A-501 Filing a Claim.

A Participant or his/her authorized representative shall make a claim for benefits under this Plan by filing a written request with the Administrator in accordance with the provisions of § 20A-402. The claims procedure set forth in the remainder of this Article shall be interpreted in accordance with the provisions of 45 CFR § 147.136 (including the incorporated provisions of 29 CFR § 2560.503-1). It is not expected that this Plan will involve any claims involving urgent care, any pre-service claims, or any concurrent care claims, as described in those regulations, and so provisions applicable to such claims are not included explicitly in this Article. However, this Plan incorporates by reference the provisions of those regulations applicable to such claims in the event any of them should arise.

[Ords. 524 12-29-2014, 525 01-14-2015, 526 01-18-2015]

§ 20A-502 Notice of Denial.

If the Administrator denies a request for benefits under § 20A-402 or § 20A-501 in whole or in part, it shall notify the claimant of the same in writing within 30 days of the date the request was filed with the Administrator (or earlier, if required by applicable law). (However, this 30-day period may be extended one time by the Administrator for up to 15 days, provided that the Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Administrator expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In that event, the time period for processing the claim shall not begin to run again until the information is received from the claimant or his/her authorized representative.) Any notice of denial shall contain, in a manner calculated to be understood by the claimant—

(a) the reason for the denial, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;

(b) specific references to the Plan provisions on which the denial is based;

(c) a description of any additional information needed to perfect the claim and an explanation of why such information is necessary;

(d) an explanation of the Plan's claim procedure, including the opportunity for appeal and review, applicable time limits, and how to initiate an appeal and review under the following provisions of this Article;

(e) in the event an internal rule, guideline, protocol, or similar criterion was relied upon in making the determination, a copy of such rule or guideline, etc. shall be attached;

(f) if the determination was based on a medical necessity, experimental, or a similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the claimant's medical circumstances shall be attached;

(g) a statement indicating that the claimant shall be provided, upon request and free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(h) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable);

(i) a statement that, upon request and free of charge, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning will be provided; *and*

(j) contact information for the office of health insurance consumer assistance or ombudsman.

If such notification is not given within the above 30 day (or shorter) period, the claimant may consider the claim denied as of the last day of such period.

[Ords. 524 12-29-2014, **525** 01-14-2015, **526** 01-18-2015**]**

§ 20A-503 Internal Appeal of Denial.

(a) Petition. A claimant or his/her authorized representative may petition the Administrator in writing for an internal appeal of the denial of any claim within 180 days after the receipt of a notice of denial under § 20A-502, or at any time after the claimant may consider his claim denied under § 20A-502 and before the claimant receives a formal notice from the Administrator under § 20A-502. A claimant should submit written comments, documents, records, and all other information relating to the claim for benefits. A claimant may request reasonable access to and copies of all documents, records, and other information relevant to the claim, which shall be provided to the claimant free of charge. The appeal before the Administrator will take into account all comments, documents, records and other information that is submitted, regardless of whether such information was submitted and considered in the initial determination of the claim. The claimant will also be provided an internal appeal that does not afford deference to the initial adverse determination, and which is conducted by someone who is neither the individual who made the initial determination, nor the subordinate of such individual. If any new or additional information is considered, relied upon, or generated by or at the direction of the Plan or the Administrator in connection with the internal appeal, such evidence must be provided, free of charge, to the claimant as soon as possible and sufficiently in advance of the date by which the notice of final internal appeal determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(b) Medical Judgment. If the internal appeal before the Administrator involves a determination based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment or other item is experimental, investigational, or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the review will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection

with the initial determination that is the subject of the appeal, nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the appeal.

(c) Final Decision by Administrator. If the Administrator still denies the claim following an appeal under subsection (a), the Administrator shall so notify the claimant in writing in accordance with the same procedures set forth in § 20A-502 for the initial determination of the Administrator (except that the 30 day period for making a decision shall not be extended). In addition, the denial shall include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

(d) New or Additional Rationale. Notwithstanding subsection (c), if a claim denial under subsection (c) is based on a new or additional rationale from that stated in the initial determination under § 20A-502, the claimant must be provided, free of charge, with the rationale; and the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal appeal determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(e) Avoiding Conflicts of Interest. In addition to the other requirements of this Section, the Plan and the Administrator must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjuster or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

[Ords. 524 12-29-2014, **525** 01-14-2015, **526** 01-18-2015**]**

§ 20A-504 External Review.

(a) State Procedure. If this Plan is subject to a Pennsylvania external review procedure that applies to and is binding on this Plan, which includes at a minimum the consumer protections in the NAIC Uniform Model Act (within the meaning of 45 CFR § 147.136), then this Plan must comply with the applicable Pennsylvania external review process and is not required to comply with the Federal external review process under subsection (b).

(b) Federal Procedure. If this Plan is not subject to a Pennsylvania external review procedure under subsection (a), then it must provide an effective Federal external review process under 45 CFR § 147.136(d) (except with respect to a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a person fails to meet the requirements for eligibility under the terms of the Plan). Until further information is provided by the regulatory agencies, a Federal external review must be filed by the claimant or his/her authorized representative with the external reviewer within four (4) months of the date the claimant was served with the decision under § 20A-503, or the claimant shall lose the right to an external review and appeal. The Plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the Plan, the claimant provided all of the necessary information to process the external review, and

that the claimant has exhausted the internal appeals process. The Plan must provide the claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan will permit the claimant to perfect the external review request within the four (4) month period or, if later, 48 hours after receipt of the notice. The Plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify the claimant and the Plan Administrator of its decision within 45 days after its receipt of the request for external review. The external reviewer's decision is binding on the parties unless other State or Federal law remedies are available. The Plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. Notwithstanding anything to the contrary in this subsection (b), until further requirements by the regulatory agencies, this Plan shall comply with the U.S. Department of Labor's private accredited independent review organization (IRO) process described in EBSA Technical Release 2010-01, dated August 23, 2010, as modified, under U.S. Department of Health and Human Services Technical Guidance issued July 22, 2011. The Administrator, on behalf of the Plan, shall contract with at least three IROs and must rotate assignments among the IROs.

[Ords. 525 01-14-2015, 526 01-18-2015]

§ 20A-505 Adverse Benefit Determination.

The provisions of this Article V with respect to the denial, appeal, and review of a claim shall also apply to all other adverse benefit determinations as defined in 29 CFR § 2560.503-1, as well as any rescission of coverage, as described in 45 CFR § 147.128, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

[Ord. 526 01-18-2015]

Article VI — Administration

§ 20A-601 In General.

The Plan Administrator of this Plan shall be Equinox Agency, 1275 Glenlivet Drive, Suite 340, Allentown, Pennsylvania, or such successor as shall be appointed by the Borough Council of the Borough of Alburtis. The Employer shall make payments of benefits approved by the Administrator.

[Ords. 524 12-29-2014, 526 01-18-2015]

§ 20A-602 Powers and Duties.

(a) In General. The Administrator shall administer the Plan in accordance with its terms, and shall have all powers necessary to carry out the provisions of the Plan. The Administrator shall have absolute and exclusive discretion to decide all issues arising in the administration, interpretation, and application of the Plan (including, but not limited to, the power to supply omissions, correct defects, and resolve inconsistencies and ambiguities). The Administrator may from time to time set forth rules of interpretation and administration, subject to modification as appropriate in the light of experience. Decisions and rules established by the Administrator shall be conclusive and binding on all persons. The Administrator shall act without discrimination among persons similarly situated at any given time, although it may change its policies from time to time, and shall always act in the exclusive interest of Plan Participants and Covered Family Members.

(b) Delegation. The Administrator may delegate to any person or group of persons its authority to perform any act under this Plan, including those matters involving the exercise of discretion, *provided* that such delegation shall be in writing and subject to revocation at any time at the Administrator's discretion.

(c) Employment of Professionals and Others. The Administrator may appoint such accountants, counsel, specialists, consultants, and other persons as it may deem necessary or desirable in connection with the administration of this Plan, including persons who may also be engaged by the Employer. The Administrator shall be entitled to rely exclusively upon, and shall be fully protected in any action taken in good faith by it in relying upon, any opinions or reports which shall be furnished to it by any such accountant, counsel, specialist, or other consultant.

(d) Records. The Administrator shall keep a record of all its proceedings and acts, and shall keep all such books of account, records, and other data as may be necessary for the proper administration of the Plan in accordance with applicable law.

(e) Reports, Documents, and Communications. The Administrator shall prepare and file all reports and documents required to be filed with a governmental agency, shall prepare and provide or make available all reports and documents required to be provided or made available to Participants or persons with an interest under the Plan, and shall communicate with employees and other persons with respect to all matters relating to the Plan, including rights and benefits under this Plan.

[Ords. 524 12-29-2014, **526** 01-18-2015**]**

§ 20A-603 Indemnification.

The Employer hereby agrees to indemnify any officer, director, or employee of the Employer for any expenses, penalties, damages, or other pecuniary losses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) which such person may suffer as a result of the good faith exercise of his responsibilities, obligations, or duties in connection with the Plan or fiduciary activities actually performed in connection with the Plan, *but only* to the extent permitted by law and fiduciary liability insurance or bond is not available to cover the payment of such item.

[Ord. 524 12-29-2014]

§ 20A-604 Benefits Solely From General Assets.

Except as may otherwise be required by law—

(a) nothing herein will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant or Covered Family Member; and

(b) no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Employer for which any payment under the Plan may be made.

[Ords. 524 12-29-2014, 526 01-18-2015]

§ 20A-605 Spendthrift Provisions.

Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for support of a spouse, former spouse, or any other relative or dependent of the Participant before actually being received by the Participant or his representative or beneficiary under the terms of this Plan. Any attempt to anticipate, alienate, transfer, assign, pledge, encumber, change, or otherwise dispose of any right to benefits payable under this Plan shall be void. The Administrator and the Employer shall not be liable for or subject to, in any manner, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits under this Plan.

[Ord. 524 12-29-2014]

§ 20A-606 Facility of Payment.

Whenever the Employer determines that a person entitled to receive any payment of a benefit or installment is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Employer may make payments to such person, to his legal representative, to a relative, or to a friend of such person for his benefit. Any payment of a benefit or installment in accordance with the provisions of this Section shall be a complete discharge from any liability for the making of such payment under the provisions of the Plan.

[Ords. 524 12-29-2014, 526 01-18-2015]

Article VII — Amendment and Termination

§ 20A-701 Amendment of Plan.

The Employer reserves the right to amend this Plan to any extent and in any manner that it may deem advisable at any time by ordinance of the Sponsor, so long as it does not interfere with benefits which have accrued with respect to Qualifying Medical Care Expenses incurred prior to the *later* of the ordinance's adoption date or effective date.

[Ord. 524 12-29-2014**]**

§ 20A-702 Termination of Plan.

Although the Employer has established this Plan with the bona fide intention and expectation to continue this Plan indefinitely, the Employer will have no obligation whatsoever to maintain the Plan for any given length of time, and the Employer reserves the right to terminate this Plan at any time by ordinance of the Sponsor, without liability. Following termination of the Plan, the Plan will continue to reimburse Qualifying Medical Care Expenses incurred prior to the date of termination in accordance with the provisions of this Chapter as in effect immediately before the Plan's termination.

[Ord. 524 12-29-2014**]**