BOROUGH OF ALBURTIS
LEHIGH COUNTY, PENNSYLVANIA

Ordinance No. 524

(Duly Adopted December 29, 2014)

AN ORDINANCE REVISING THE COMPENSATION OR COMPENSATION RANGES FOR CERTAIN POSITIONS OF EMPLOYMENT OR APPOINTMENT BY THE BOROUGH, EFFECTIVE JANUARY 1, 2015, INCLUDING CERTAIN ADMINISTRATION EMPLOYEES, MAINTENANCE EMPLOYEES, PROFESSIONALS, AND THE ZONING OFFICER; CONTINUING THE COMPENSATION AND BENEFITS (OTHER THAN HEALTH BENEFITS) FOR POLICE DEPARTMENT EMPLOYEES EFFECTIVE JANUARY 1, 2015 AT THE SAME RATES AS IN EFFECT IN 2014, PENDING THE EXECUTION OF A NEW COLLECTIVE BARGAINING AGREEMENT OR THE ISSUANCE OF A FINAL INTEREST ARBITRATION AWARD; CHANGING THE HEALTH BENEFIT PLAN PROVIDED BY THE BOROUGH EFFECTIVE JANUARY 1, 2015 TO THE CAPITAL ADVANTAGE ASSURANCE COMPANY HEALTHY BENEFITS PPO 2000.0 PD RX $0 PLAN; PROVIDING THAT NON-UNIFORMED EMPLOYEES PARTICIPATING IN THE HEALTH PLAN CONTRIBUTE FIVE PERCENT (5%) OF THE COST OF THE COVERAGE ELECTED; PROVIDING THAT POLICE OFFICERS PARTICIPATING IN THE HEALTH PLAN ARE NOT REQUIRED TO CONTRIBUTE TOWARD THE COST OF THEIR COVERAGE, PENDING THE EXECUTION OF A NEW COLLECTIVE BARGAINING AGREEMENT OR THE ISSUANCE OF A FINAL INTEREST ARBITRATION AWARD; CHANGING THE RESTRICTIONS ON THE ABILITY OF NON-UNIFORMED EMPLOYEES TO ELECT SPOUSAL COVERAGE UNDER THE HEALTH PLAN SUCH THAT SPOUSAL COVERAGE MAY NOT BE ELECTED IF THE SPOUSE IS ELIGIBLE FOR MINIMUM VALUE HEALTH COVERAGE FROM OTHER EMPLOYMENT AND NEED NOT CONTRIBUTE MORE THAN THIRTY PERCENT (30%) OF THE COST OF SUCH COVERAGE; ELIMINATING THE RESTRICTIONS ON THE ABILITY OF NON-UNIFORMED EMPLOYEES TO ELECT DEPENDENT COVERAGE FOR DEPENDENTS WHO ARE ELIGIBLE FOR HEALTH COVERAGE FROM OTHER EMPLOYMENT; ESTABLISHING A NEW HEALTH REIMBURSEMENT ARRANGEMENT FOR FULL-TIME NON-UNIFORMED EMPLOYEES TO PROVIDE BOROUGH-PAID REIMBURSEMENTS OF DEDUCTIBLES UNDER THE NEW

HEALTH PLAN, SUBJECT TO A $300 ANNUAL INDIVIDUAL DEDUCTIBLE AND $600 ANNUAL FAMILY DEDUCTIBLE; ESTABLISHING A NEW HEALTH REIMBURSEMENT ARRANGEMENT FOR FULL-TIME POLICE OFFICERS TO PROVIDE BOROUGH-PAID REIMBURSEMENTS OF ALL DEDUCTIBLES UNDER THE NEW HEALTH PLAN, AND OF CO-PAYMENTS UNDER THE NEW HEALTH PLAN TO THE EXTENT THE CO-PAYMENTS ARE HIGHER THAN THEY WERE UNDER THE BOROUGH'S HEALTH PLAN IN EFFECT IN 2014, PENDING THE EXECUTION OF A NEW COLLECTIVE BARGAINING AGREEMENT OR THE ISSUANCE OF A FINAL INTEREST ARBITRATION AWARD; MAKING CONFORMING CHANGES TO THE CAFETERIA PLAN AND THE MEDICAL EXPENSE REIMBURSEMENT PLAN; AND CONFIRMING THE EXISTING FIDELITY BOND REQUIREMENTS FOR CERTAIN BOROUGH EMPLOYEES.

WHEREAS, Borough Council desires to revise the compensation or compensation ranges for certain positions of employment or appointment by the Borough as set forth below, effective January 1, 2015; and

WHEREAS, Borough Council desires to change the health benefit plans provided by the Borough to its employees, effective January 1, 2015; and

WHEREAS, Borough Council desires to make other employee benefit changes as set forth in this ordinance; and

WHEREAS, Borough Council desires to confirm the existing fidelity bond requirements for certain Borough employees; and

WHEREAS, on December 17, 2014, the Borough published a public notice in the *East Penn Press*, a newspaper of general circulation in the Borough of Alburtis, of its intention to consider and adopt on this Ordinance on December 29, 2014;

NOW, THEREFORE, be it **ORDAINED** and **ENACTED** by the Borough Council of the Borough of Alburtis, Lehigh County, Pennsylvania, as follows:

SECTION 1. Codified Ordinances §§ 11-104, 11-106, and 11-108 (relating to Salaries and Compensation—In General) are amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 11-104 Administration.

(a) Executive Secretary.

* * *

(13) 2015. The annual salary of the Executive Secretary for the year 2015 shall be $53,612.

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(c) Borough Treasurer.

* * *

(12) 2015. The rate of compensation of the Borough Treasurer for the year 2015 shall be $16.29 per hour.

§ 11-105 Police Department.

*** * ***

(e) 2015. Until further action by Council in accordance with a new collective bargaining agreement or final interest arbitration award, the rate of compensation for members of the Police Department for the year 2015 shall be the same as provided in 2014 under the Alburtis Police 2012-2014 Collective Bargaining Agreement. *See* § 11-201(d) (relating to Police Collective Bargaining Agreement).

§ 11-106 Maintenance Department.

* * *

(m) 2015. The rate of compensation for each member of the Maintenance Department for the year 2014 shall be established by motion

or resolution of Council within the following range of compensation for the person's employment classification:

Maintenance Supervisor..... $19.95 - $26.57 / hour
Maintenance Full Time A ..... $19.10 - $23.41 / hour
Maintenance Full Time B ..... $18.49 - $19.60 / hour
Maintenance Full Time C ..... $16.56* - $18.49 / hour
Maintenance Part Time ..... $ 8.59 - $13.00 / hour

* In the case of a person who has a current Class A or Class B commercial driver's license (CDL) when first hired by the Borough, the minimum hourly rate shall be $17.84. In the case of a person who obtains such a license after being hired by the Borough, the minimum hourly rate shall be increased to $17.84 after the *later* of the date the person obtains the license or the date three months after the person's first day of employment as a Borough maintenance department employee.

§ 11-107 Codes Enforcement.

(a) Zoning Officer.

(7) 1/1/2015. Effective January 1, 2015, the compensation of the Zoning Officer shall be $412.00 per month plus $10.00 for each permit issued.

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§ 11-108 Professionals.

(a) Borough Solicitor.

* * *

(12) 2015. The rate of compensation of the Borough Solicitor for the year 2015 shall be $155.00 per hour.

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SECTION 2. Effective January 1, 2015, Alburtis Codified Ordinances § 12-102 (relating to Personnel Policies—Title and Scope—Scope) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining)

§ 12-102 Scope.

This Chapter shall apply to all non-uniformed employees of the Borough of Alburtis. This Chapter shall also apply to uniformed police department employees of the Borough of Alburtis except to the extent of any conflict with Chapter 13 (relating to Police Civil Service), any applicable collective bargaining agreement, or any applicable law, regulation, or final court decision, or unless specifically stated to the contrary in this Chapter. Until further action by Council in accordance with a new collective bargaining agreement or final interest arbitration award, the provisions of the Alburtis Police 2012-2014 Collective Bargaining Agreement applicable in calendar year 2014 shall contine to apply on and after January 1 2015, unless specifically stated to the contrary in this Chapter. *See* § 11-201(d) (relating to Police Collective Bargaining Agreement).

SECTION 3. Effective January 1, 2015, Codified Ordinances § 12-403 (relating to Personnel Policies—Benefits—Health & Hospitalization) is amended by amending subsection (a), amending paragraphs (1), (2), and (2.1) of subsection (b.1), amending subsection (d), and adding a new subsection (e), as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 12-403 Health & Hospitalization.

(a) In General. Subject to the payment of employee premium contributions as set forth in subsection (b.1), medical coverage is provided to full-time Borough employees effective the first day of the third calendar month following the calendar month in which the person commences

employment as a full-time Borough employee. The employee may elect, from time to time, whether this coverage is to be provided to the employee alone or to the employee and the employee's spouse and/or one or more of the employee's eligible family members, except as otherwise provided in subsection (d). The terms, conditions, limitations, restrictions, deductibles, co-payments, scope of coverage, as well as the persons eligible for coverage, are described in the summary plan descriptions distributed from time to time to employees and in the health policies and contracts obtained by the Borough from time to time. Nothing in this Chapter shall provide any specific medical benefits; all such benefits shall be provided by policies as authorized from time to time by action of Council. As of January 1, ~~2014~~ 2015, the coverage provided under this Section is the product known as Healthy Benefits PPO ~~0~~ 2000 . 0 ~~$10~~ PD . Rx $0, as offered and renamed from time to time by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross which takes over that product). To the extent this Section is inconsistent with the provisions of the ~~current~~ 2012-14 collective bargaining agreement for police officers, the provisions of the collective bargaining agreement as in effect for calendar year 2014 shall apply with respect to full-time police officers, except that the health benefit plan to be provided to full-time police officers effective January 1, 2015 shall be the product known as Healthy Benefits PPO 2000 . 0 PD . Rx $0, as offered and renamed from time to time by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross which takes over that product). Full-time police officers shall not be required to contribute toward the cost of this health coverage, and shall be eligible for the Health Reimbursement Arrangement for Police Employees (*see* § 12-403(e)).

* * *

(b.1) Employee Contributions to Premiums.

* * *

(2) Amount of Employee Contributions. The percentage of the monthly premium charged to the Borough which must be contributed by the full-time Borough employee is—

* * *

(C) ~~2014+~~ 2014. ~~Six percent (6.0%) for months beginning on or after January 1, 2014.~~ Zero percent (0.0%) for months in calendar year 2014.

(D) 2015+. Five percent (5.0%) for months beginning on or after January 1, 2015.

~~(2.1) Contributions Suspended for 2014.~~ ~~Notwithstanding paragraphs (1) and (2), the monthly employee contributions shall be suspended for calendar year 2014, so that no full-time Borough employee must contribute any amount towards coverage under the new Healthy Benefits PPO plan in 2014.~~

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(d) Working Spouses ~~and Dependents~~. Notwithstanding anything to the contrary in this Section, no health coverage may be elected or provided for any period after December 31, ~~2007~~ 2014 with respect to a spouse ~~or family member~~ of a full-time Borough employee for any month in which such spouse ~~or family member~~ is eligible to participate as an employee in a group health plan sponsored by another employer, *unless* ~~such spouse or family member elects to participate in the other employer's plan and that other plan is the primary coverage for the spouse or family member~~ (1) no coverage for which the spouse is eligible under his/her employer's group health plan(s) provides "minimum value" within the meaning of the Patient Protection and Affordable Care Act and the regulations thereunder *or* (2) the spouse is required to contribute more than thirty percent (30%) of the premium cost for coverage for the spouse under all "minimum value" coverage options available to the spouse under his/her employer's group health plan(s). A full-time Borough employee who desires to cover a spouse ~~or family member~~ must provide, from time to time upon request, proof that the spouse ~~or family member~~ is not employed, or, if employed, that the spouse ~~or family member is either not eligible to participate in the employer's health plan or is participating in the employer's plan~~ is either not eligible for "minimum value" coverage under a group health plan of his/her employer, or is required to contribute more than thirty percent (30%) of the premium cost for his/her coverage

under all "minimum value" coverage options available to his/her under his/her employer's group health plan.

(e) Health Reimbursement Arrangements. Certain deductibles and/or co-payments payable under the medical coverage provided by this Section may be reimbursable to the employee under the Health Reimbursement Arrangements provided by the Borough under Chapter 20A (relating to Health Reimbursement Arrangement for Non-Uniformed Employees) or Chapter 20B (relating to Health Reimbursement Arrangement for Police Employees).

SECTION 4. Effective January 1, 2015, Codified Ordinances § 14-109 (relating to Cafeteria Plan—Title, Establishment, and General Definitions—Health Plan) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 14-109 Health Plan.

The term "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, ~~2014~~ 2015, the Health Plan is the product known as Healthy Benefits PPO ~~0~~ 2000 . 0 ~~$10~~ 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.

SECTION 5. Effective January 1, 2015, Codified Ordinances § 20-116 (relating to Medical Expense Reimbursement Plan—Title, Establishment, and General Definitions—Qualifying Medical Care Expenses) is amended by amending subsection (c)(1) as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20-116 Qualifying Medical Care Expenses.

* * *

(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), including but not limited to reimbursements available under the health/medical/hospitalization plan of the Employer under § 12-403, and the health reimbursement arrangements under Chapters 20A and 20B. Any deductibles under these health reimbursement arrangements that are not reimbursed or entitled to reimbursement through insurance or otherwise (other than under this Plan) are not excluded under this paragraph (1);

* * *

SECTION 6. The Codified Ordinances are hereby amended by adding the following new Chapter 20A:

Chapter 20A — Health Reimbursement Arrangement for Nonuniformed Employees

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."

§ 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.

§ 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.

§ 20A-104 Administrator.

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

§ 20A-105 Claims Administrator.

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

§ 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.

§ 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.

§ 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), exceupt 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; or

(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.

§ 20A-109 Effective Date.

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

§ 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.

§ 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.

§ 20A-112 HRA Deductible.

(a) 2015. For calendar year 2015, 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).

§ 20A-113 Maximum Coverage Amount.

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

§ 20A-114 Participant.

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

§ 20A-115 Period of Coverage.

The term "Period of Coverage" shall mean the Plan Year, except that for a person 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.

§ 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.

§ 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.

§ 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.

§ 20A-119 [RESERVED]

§ 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).

§ 20A-121 Qualifying Medical Care Expenses.

(a) In General. Except as provided otherwise in this § 20A-116, 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-116, 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.

§ 20A-122 Related Employer.

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.

§ 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.

§ 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.

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.

§ 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 (b) 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.

§ 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.

§ 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.

§ 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 Partipant may permanently opt out of and waive future reimbursements from this Plan for expenses incurred after the date of the termination.

§ 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 Contiunation 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 preceditng 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 preceditng year.

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.

§ 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.

§ 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.

§ 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.

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.

§ 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 Claims Administrator on such forms as the Claims 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 Claims 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 Claims 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.

§ 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 be made following final approval by Borough Council at a public meeting.

§ 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.

§ 20A-405 HRA Deductibles.

(a) Individual Deductible. Nothwithstanding 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), 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 anount shall be reimbursable by this Plan (subject to the procedures and limitations of this Chapter other than subsection (a)).

§ 20A-406 Death of 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.

§ 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 Partipant or the Participant's representative for Qualifying Medical Care Expenses shall completely discharge all liability of this Plan, the Claims Administrator, the Administrator, and the Employer with respect to such expenses.

§ 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.

§ 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 Administrator may, without anyone's consent, terminate that person's coverage under this Plan without any right to future reinstatement, and the Administrator and Claims Administrator may refuse to honor any claims by such person under this Plan.

Article V — Claims Procedure

§ 20A-501 Filing a Claim.

A Participant or his representative shall make a claim for benefits under this Plan by filing a written request with the Claims Administrator in accordance with the provisions of § 20A-402.

§ 20A-502 Notice of Denial.

If the Claims 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 Claims Administrator (or earlier, if required by applicable law). Any notice of denial shall contain—

(a) the reason for the denial;

(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; *and*

(d) an explanation of the Plan's claim procedure, including the opportunity for review under § 20A-503.

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.

§ 20A-503 Review of Denial.

(a) Petition. A claimant may petition the Claims Administrator in writing for a review 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 Claims Administrator under § 20A-502. A claimant should submit written comments, documents, records, and all other information relating to the claim forbenefits. 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 review by the Claims 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 a review 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.

(b) Final Decision by Claims Administrator. If the Claims Administrator still denies the claim following a review under subsection (a), the Claims 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 Claims Administrator.

(c) Appeal to the Administrator. A claimant may petition the Administrator in writing for a review of the final denial of any claim by the Claims Administrator under subsection (b) within 60 days after the receipt of a notice of denial under subsection (b), or at any time after the claimant may consider his review denied and before the claimant receives a formal notice from the Claims Administrator that the review was denied under subsection (b).

(d) Rights. With respect to any review by the Administrator under this Section, the claimant shall have the right—

(1) to a hearing;

(2) to representation;

(3) to review pertinent documents;

(4) to submit comments in writing within 60 days of the receipt of the notice of denial under subsection (b); *and*

(5) to all rights afforded under subsection (f).

(e) Decision. The Administrator shall issue a written decision at the conclusion of a review under subsections (c) and (d) within 30 days following its receipt of a petition for such review. Such decision shall give specific reasons for the decision and provide specific references to the plan provisions on which it is based. If the decision is not made within such time period, the claim will be considered denied.

(f) Compliance with Local Agency Law. All reviews by the Administrator under this § 20A-503 shall comply with the provisions of the Local Agency Law, 2 PA. CONS. STAT. § 551 *et seq*.

Article VI — Administration

§ 20A-601 In General.

The Plan Administrator of this Plan shall be the Borough Council of the Borough of Alburtis.

§ 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.

(1) In General. 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.

(2) Claims Administrator. Subject to revocation under paragraph (1), the Administrator hereby appoints Equinox Agency, 1275 Glenlivet Drive, Suite 340, Allentown, Pennsylvania, as the Claims Administrator of this Plan, and delegates to the Claims Administrator the powers and duties to receive and adjudicate applications and claims for benefits under Articles IV and V, and to report the results of its decisions to the Administrator. The Employer shall make payments of benefits approved by the Claims Administrator (although the Administrator may first request the Claims Administrator to review any concerns raised by the Administrator based on the provisions of this Chapter or applicable law). The Claims Administrator shall have the authority and disccretion to interpret this Chapter with respect to its duties and to decied questions and

disputes arising under this Chapter with respect to such duties, which interpretations and decisions shall be final and binding for purposes of this Plan, subject to any right of Participants to appeal the interpretations and decisions under Article V.

(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.

§ 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.

§ 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.

§ 20A-605 Spendthrift Provisions.

Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, change, 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.

§ 20A-606 Facility of Payment.

Whenever the Administrator 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 Administrator 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.

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.

§ 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.

Article VIII — Tax Implications

§ 20A-801 No Guarantee of Tax Consequences.

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for

federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from his gross income for federal and state income tax purposes, and to notify the Employer if he has reason to believe that any such payment is not so excludable.

§ 20A-802 Indemnification of Employer by Participants.

If any Participant receives one or more payments or reimbursements under this Plan that are not for Qualifying Medical Care Expenses or are not excludable from federal, state, or local income or Social Security taxes, and such taxes were not withheld from such payments or reimbursements, the Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold such taxes from such payments or reimbursements, and shall indemnify and reimburse the Plan for any payments made which were not for Qualifying Medical Care Expenses.

Article IX — HIPAA Privacy and Security Practices

§ 20A-901 In General.

This Plan, the Claims Administrator, the Administrator, and the Employer shall comply in all respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder from time to time, including the administrative simplification provisions, the provisions that govern the privacy of Protected Health Information as set forth in 45 CFR Part 160 and Part 164, Subparts A and E, and the provisions that govern the security of Protected Health Information as set forth in 45 CFR Part 160 and Part 164, Subparts A and C. All of these provisions are incorporated into this Article by reference as if set forth in full. The

HIPAA privacy and security official of the Employer is the Borough Execeutuive Secretary.

Article X — Miscellaneous

§ 20A-1001 Acquittance.

This Plan is purely voluntary on the part of the Employer. Except as provided in this Chapter, neither the establishment of the Plan, any modification thereof, nor the payment of any benefits under the Plan shall be construed as giving to any Participant or any other person any legal or equitable right against the Employer, any officer or Employee of the Employer, the Administrator, or the Claims Administrator.

§ 20A-1002 Limitation of Liability.

Each person who becomes a Participant under this Plan expressly agrees and understands that neither the Employer, the Administrator, the Claims Administsrator, nor any of their officers and agents shall be subject in any way to any suit or litigation, or to any personal liability for any reason whatsoever in connection with this Plan or its operation, *except* for their willful neglect or fraud.

§ 20A-1003 Employment Rights.

Nothing contained in this Plan shall be construed or interpreted as giving any employee of the Employer the right to be retained in the service of any Employer or shall affect or impair any terms of employment with any Employer, the right of any Employer to control its employees, and the right of any Employer to terminate the service of any employee at any time, subject to applicable provisions of law and applicable collective bargaining agreements.

§ 20A-1004 Information to be Furnished.

Participants shall provide the Employer, the Administrator, and the Claims Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering the Plan.

§ 20A-1005 Delegation of Authority by Employer.

Whenever any Employer is permitted or required to do or perform any act, matter, or thing under this Plan, it shall be done or performed by any officer duly authorized to perform same by the Employer.

§ 20A-1006 Interpretation.

This Plan is designed to satisfy the requirements for a health reimbursement arrangement under IRS Notices 2002-45 and 2013-54, and an accident or health plan within the meaning of Code §§ 105(e) and 106, as they may be amended from time to time, in order to qualify for exclusing from gross income for federal income tax purposes under Code § 105(b). Unless a contrary intent shall appear herein, all terms used in this Plan shall be interpreted in the same manner as corresponding terms are used in those provisions and the regulations, rulings, and interpretations issued thereunder.

§ 20A-1007 Construction.

This Plan shall be construed and administered according to the laws of the United States of America and the Commonwealth of Pennsylvania.

§ 20A-1008 Gender and Number.

Whenever any words are used in this Plan in the masculine gender, they shall be construed as though they were also used in the feminine gender in all appropriate cases. Whenever any words are used in either the

singular or plural form, they shall be construed as though they were also used in the other form in all appropriate cases.

§ 20A-1009 Headings.

Article, section, subsection, paragraph, subparagraph, clause, subclause, and other headings are included in this Chapter for convenience only and shall not be taken into account in construing the provisions of this Chapter.

§ 20A-1010 Severability.

Any provision of this Chapter which is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating or rendering unenforceable the remaining provisions of this Chapter, and any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction. To the extent permitted by applicable law, the Employer hereby waives any provision of law which renders any provision of this Chapter prohibited or unenforceable in any respect.

§ 20A-1011 USERRA and Other Statutes.

Notwithstanding anything to the contrary in this Chapter, contributions, benefits, and service credit with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act and the regulations thereunder, and contributions and benefits shall also be provided in accordance with the applicable requirements of any other federal or Pennsylvania law or regulation.

SECTION 7. The Codified Ordinances are hereby amended by adding the following new Chapter 20B:

Chapter 20B — Health Reimbursement Arrangement for Police Employees

Article I — Title, Establishment, and General Definitions

§ 20B-101 Short Title.

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

§ 20B-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.

§ 20B-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.

§ 20B-104 Administrator.

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

§ 20B-105 Claims Administrator.

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

§ 20B-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.

§ 20B-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 § 20B-204.

§ 20B-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), exceupt 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; or

(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.

§ 20B-109 Effective Date.

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

§ 20B-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.

§ 20B-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.

§ 20B-112 HRA Deductible.

(a) 2015. Prior to the execution of a new collective baragaining agreement for police employees and/or the issuance of a final interest arbitration award, for calendar year 2015, the term "HRA Deductible (Individual)" shall mean Zero Dollars ($0.00), and the term "HRA Deductible (Family)" shall mean Zero Dollars ($0.00).

§ 20B-113 Maximum Coverage Amount.

(a) 2015. For calendar year 2015, the term "Maximum Coverage Amount (Individual)" shall mean Four Thousand Dollars ($4,000.00), and the term "Maximum Coverage Amount (Family)" for calendar year 2015 shall mean Eight Thousand Dollars ($8,000.00). If the Qualified Reimbursable Expenses for a given Participant and his/her covered spouse and/or dependents in 2015 should exceed the Maximum Coverage Amounts prior to the execution of a new collective baragaining agreement for police employees and/or the issuance of a final interest arbitration

award, the Borough will reimburse the Participant for the excess amount (plus a tax adjustment) outside of this Plan.

§ 20B-114 Participant.

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

§ 20B-115 Period of Coverage.

The term "Period of Coverage" shall mean the Plan Year, except that for a person 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.

§ 20B-116 Plan.

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

§ 20B-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.

§ 20B-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.

§ 20B-119 Prior Health Plan.

The term "Prior Health Plan" shall mean the health/medical/hospitalization coverage plan provided to police employees in 2014—the product known as Healthy Benefits PPO 0 . 0 $10 PD . Rx $0, as offered to the Borough of Alburtis by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross) for 2014.

§ 20B-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) as a police officer (including the Chief of Police) and whose customary employment is at least thirty-five (35) hours per week (including permitted paid time off).

§ 20B-121 Qualifying Medical Care Expenses.

(a) In General. Except as provided otherwise in this § 20B-116, 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 or a Reimbursable Copayment. 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 § 20B-116, 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 § 20B-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.

(d) Reimbursable Copayment. For purposes of this Section, the term "Reimbursable Copayment" means expenses incurred by a Partici-

pant or his/her Covered Family Member, for Medical Care of the Participant or his/her Covered Family Member, and which are applied to a copayment under the Primary Health Plan, *but only to the extent* that the copayment for a particular service under the Primary Health Plan is greater than the copayment for that particular service under the Prior Health Plan. By way of summary (and subject to the actual provisions of the Primary Health Plan and the Prior Health Plan), the in-network copayments are as follows:

Service	Prior Health Plan	Primary Health Plan
PCP Office Visit	$10	$15
Specialist Visit	$25	$35
Urgent Care	$50	$75
Emergency Room	$100	$125
Retail Rx	$4/15/45/70	$4/15/45/70
Mail Order Rx	$10/38/113/175	$10/38/113/175
Specialty Rx	$0	$10/38/113/175

§ 20B-122 Related Employer.

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.

§ 20B-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.

§ 20B-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.

Article II — Participation

§ 20B-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.

§ 20B-202 Cessation of Participation.

(a) In General. Except as otherwise provided in this § 20B-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 (b) 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.

§ 20B-203 Reinstatement of Former Participant.

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

§ 20B-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.

§ 20B-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 Partipant may permanently opt out of and waive future reimbursements from this Plan for expenses incurred after the date of the termination.

§ 20B-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 Contiunation 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 preceditng 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 preceditng year.

Article III — HRA Accounts

§ 20B-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.

§ 20B-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.

§ 20B-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.

§ 20B-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 § 20B-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.

Article IV — Benefits

§ 20B-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.

§ 20B-402 Application for Reimbursement.

(a) Application Form. All applications for reimbursement of Qualifying Medical Care Expenses under this Plan shall be filed with the Claims Administrator on such forms as the Claims 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 Claims 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 Claims 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.

§ 20B-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 § 20B-402. Payments shall be made following final approval by Borough Council at a public meeting.

§ 20B-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.

§ 20B-405 HRA Deductibles.

(a) Individual Deductible. Nothwithstanding 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), 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 anount shall be reimbursable by this Plan (subject to the procedures and limitations of this Chapter other than subsection (a)).

§ 20B-406 Death of 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.

§ 20B-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 Partipant or the Participant's representative for Qualifying Medical Care Expenses shall completely discharge all liability of this Plan, the Claims Administrator, the Administrator, and the Employer with respect to such expenses.

§ 20B-408 Overpayments.

(a) In General. 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.

(b) CBA or Arbitration Award. This Plan is subject to any retroactive provisions of a new collective bargaining agreement or interest arbitration award for Borough police officers executed or entered after January 1, 2015. If, as a result of any such retroactive provisions, the Plan has overpaid any amount to a Participant, the overpayment shall be refunded to the Employer in accordance with subsection (a).

§ 20B-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 Administrator may, without anyone's consent, terminate that person's coverage under this Plan without any right to future reinstatement, and the Administrator and Claims Administrator may refuse to honor any claims by such person under this Plan.

Article V — Claims Procedure

§ 20B-501 Filing a Claim.

A Participant or his representative shall make a claim for benefits under this Plan by filing a written request with the Claims Administrator in accordance with the provisions of § 20B-402.

§ 20B-502 Notice of Denial.

If the Claims Administrator denies a request for benefits under § 20B-402 or § 20B-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 Claims Administrator (or earlier, if required by applicable law). Any notice of denial shall contain—

(a) the reason for the denial;

(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; *and*

(d) an explanation of the Plan's claim procedure, including the opportunity for review under § 20B-503.

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.

§ 20B-503 Review of Denial.

(a) Petition. A claimant may petition the Claims Administrator in writing for a review of the denial of any claim within 180 days after the receipt of a notice of denial under § 20B-502, or at any time after the

claimant may consider his claim denied under § 20B-502 and before the claimant receives a formal notice from the Claims Administrator under § 20B-502. A claimant should submit written comments, documents, records, and all other information relating to the claim forbenefits. 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 review by the Claims 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 a review 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.

(b) Final Decision by Claims Administrator. If the Claims Administrator still denies the claim following a review under subsection (a), the Claims Administrator shall so notify the claimant in writing in accordance with the same procedures set forth in § 20B-502 for the initial determination of the Claims Administrator.

(c) Appeal to the Administrator. A claimant may petition the Administrator in writing for a review of the final denial of any claim by the Claims Administrator under subsection (b) within 60 days after the receipt of a notice of denial under subsection (b), or at any time after the claimant may consider his review denied and before the claimant receives a formal notice from the Claims Administrator that the review was denied under subsection (b).

(d) Rights. With respect to any review by the Administrator under this Section, the claimant shall have the right—

(1) to a hearing;

(2) to representation;

(3) to review pertinent documents;

(4) to submit comments in writing within 60 days of the receipt of the notice of denial under subsection (b); *and*

(5) to all rights afforded under subsection (f).

(e) Decision. The Administrator shall issue a written decision at the conclusion of a review under subsections (c) and (d) within 30 days following its receipt of a petition for such review. Such decision shall give specific reasons for the decision and provide specific references to the plan provisions on which it is based. If the decision is not made within such time period, the claim will be considered denied.

(f) Compliance with Local Agency Law. All reviews by the Administrator under this § 20B-503 shall comply with the provisions of the Local Agency Law, 2 PA. CONS. STAT. § 551 *et seq*.

Article VI — Administration

§ 20B-601 In General.

The Plan Administrator of this Plan shall be the Borough Council of the Borough of Alburtis.

§ 20B-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.

(1) In General. 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.

(2) Claims Administrator. Subject to revocation under paragraph (1), the Administrator hereby appoints Equinox Agency, 1275 Glenlivet Drive, Suite 340, Allentown, Pennsylvania, as the Claims Administrator of this Plan, and delegates to the Claims Administrator the powers and duties to receive and adjudicate applications and claims for benefits under Articles IV and V, and to report the results of its decisions to the Administrator. The Employer shall make payments of benefits approved by the Claims Administrator (although the Administrator may first request the Claims Administrator to review any concerns raised by the Administrator based on the provisions of this Chapter or applicable law). The Claims Administrator shall have the authority and disccretion to interpret this Chapter with respect to its duties and to decied questions and disputes arising under this Chapter with respect to such duties, which interpretations and decisions shall be final and binding for purposes of this Plan, subject to any right of Participants to appeal the interpretations and decisions under Article V.

(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.

§ 20B-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.

§ 20B-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.

§ 20B-605 Spendthrift Provisions.

Benefits payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, change, 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.

§ 20B-606 Facility of Payment.

Whenever the Administrator 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 Administrator 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.

Article VII — Amendment and Termination

§ 20B-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.

§ 20B-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.

Article VIII — Tax Implications

§ 20B-801 No Guarantee of Tax Consequences.

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from his gross income for federal and state income tax purposes, and to notify the Employer if he has reason to believe that any such payment is not so excludable.

§ 20B-802 Indemnification of Employer by Participants.

If any Participant receives one or more payments or reimbursements under this Plan that are not for Qualifying Medical Care Expenses or are

not excludable from federal, state, or local income or Social Security taxes, and such taxes were not withheld from such payments or reimbursements, the Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold such taxes from such payments or reimbursements, and shall indemnify and reimburse the Plan for any payments made which were not for Qualifying Medical Care Expenses.

Article IX — HIPAA Privacy and Security Practices

§ 20B-901 In General.

This Plan, the Claims Administrator, the Administrator, and the Employer shall comply in all respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder from time to time, including the administrative simplification provisions, the provisions that govern the privacy of Protected Health Information as set forth in 45 CFR Part 160 and Part 164, Subparts A and E, and the provisions that govern the security of Protected Health Information as set forth in 45 CFR Part 160 and Part 164, Subparts A and C. All of these provisions are incorporated into this Article by reference as if set forth in full. The HIPAA privacy and security official of the Employer is the Borough Exeeutuive Secretary.

Article X — Miscellaneous

§ 20B-1001 Acquittance.

This Plan is purely voluntary on the part of the Employer. Except as provided in this Chapter, neither the establishment of the Plan, any modification thereof, nor the payment of any benefits under the Plan shall

be construed as giving to any Participant or any other person any legal or equitable right against the Employer, any officer or Employee of the Employer, the Administrator, or the Claims Administrator.

§ 20B-1002 Limitation of Liability.

Each person who becomes a Participant under this Plan expressly agrees and understands that neither the Employer, the Administrator, the Claims Administsrator, nor any of their officers and agents shall be subject in any way to any suit or litigation, or to any personal liability for any reason whatsoever in connection with this Plan or its operation, *except* for their willful neglect or fraud.

§ 20B-1003 Employment Rights.

Nothing contained in this Plan shall be construed or interpreted as giving any employee of the Employer the right to be retained in the service of any Employer or shall affect or impair any terms of employment with any Employer, the right of any Employer to control its employees, and the right of any Employer to terminate the service of any employee at any time, subject to applicable provisions of law and applicable collective bargaining agreements.

§ 20B-1004 Information to be Furnished.

Participants shall provide the Employer, the Administrator, and the Claims Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time to time for the purpose of administering the Plan.

§ 20B-1005 Delegation of Authority by Employer.

Whenever any Employer is permitted or required to do or perform any act, matter, or thing under this Plan, it shall be done or performed by any officer duly authorized to perform same by the Employer.

§ 20B-1006 Interpretation.

This Plan is designed to satisfy the requirements for a health reimbursement arrangement under IRS Notices 2002-45 and 2013-54, and an accident or health plan within the meaning of Code §§ 105(e) and 106, as they may be amended from time to time, in order to qualify for exclusing from gross income for federal income tax purposes under Code § 105(b). Unless a contrary intent shall appear herein, all terms used in this Plan shall be interpreted in the same manner as corresponding terms are used in those provisions and the regulations, rulings, and interpretations issued thereunder.

§ 20B-1007 Construction.

This Plan shall be construed and administered according to the laws of the United States of America and the Commonwealth of Pennsylvania.

§ 20B-1008 Gender and Number.

Whenever any words are used in this Plan in the masculine gender, they shall be construed as though they were also used in the feminine gender in all appropriate cases. Whenever any words are used in either the singular or plural form, they shall be construed as though they were also used in the other form in all appropriate cases.

§ 20B-1009 Headings.

Article, section, subsection, paragraph, subparagraph, clause, subclause, and other headings are included in this Chapter for convenience only and shall not be taken into account in construing the provisions of this Chapter.

§ 20B-1010 Severability.

Any provision of this Chapter which is prohibited or unenforceable in any jurisdiction shall, as to such jurisdiction, be ineffective to the extent of such prohibition or unenforceability without invalidating or rendering unenforceable the remaining provisions of this Chapter, and any such prohibition or unenforceability in any jurisdiction shall not invalidate or render unenforceable such provision in any other jurisdiction. To the extent permitted by applicable law, the Employer hereby waives any provision of law which renders any provision of this Chapter prohibited or unenforceable in any respect.

§ 20B-1011 USERRA and Other Statutes.

Notwithstanding anything to the contrary in this Chapter, contributions, benefits, and service credit with respect to qualified military service shall be provided in accordance with the Uniformed Services Employment and Reemployment Rights Act and the regulations thereunder, and contributions and benefits shall also be provided in accordance with the applicable requirements of any other federal or Pennsylvania law or regulation.

SECTION 8. Codified Ordinances § 3-101 (relating to Fidelity Bonds) is ratified and confirmed for calendar year 2015.

DULY ORDAINED and **ENACTED** by the Borough Council of the Borough of Alburtis, this 29th day of December, 2014, in lawful session duly assembled.

BOROUGH COUNCIL
BOROUGH OF ALBURTIS

_____
Steven R. Hill, President

Attest:

_____
Sharon Trexler, Executive Secretary

AND NOW, this 29th day of December, 2014, the above Ordinance is hereby APPROVED.

_____
Kathleen Palmer, Mayor