BOROUGH OF ALBURTIS
LEHIGH COUNTY, PENNSYLVANIA

Ordinance No. 525

(Duly Adopted January 14, 2015)

AN ORDINANCE AMENDING CODIFIED ORDINANCES SECTION 12-403(d) TO CHANGE THE RESTRICTIONS ON THE ABILITY OF NON-UNIFORMED EMPLOYEES TO ELECT SPOUSAL COVERAGE UNDER THE BOROUGH'S HEALTH PLAN SUCH THAT SPOUSAL COVERAGE MAY NOT BE ELECTED IF THE SPOUSE IS ELIGIBLE FOR MINIMUM VALUE HEALTH COVERAGE FROM OTHER EMPLOYMENT (REGARDLESS OF THE COST FOR SUCH COVERAGE TO THE SPOUSE); AMENDING CODIFIED ORDINANCES SECTION 20-205(b) TO EXPAND THE DISCUSSION OF CONTINUATION COVERAGE UNDER THE MEDICAL EXPENSES REIMBURSEMENT PLAN; AMENDING THE CAFETERIA AND MEDICAL EXPENSE REIMBURSEMENT PLANS AND THE HEALTH REIMBURSEMENT ARRANGEMENTS TO INCLUDE ALTERNATE RECIPIENTS UNDER QUALIFIED MEDICAL CHILD SUPPORT ORDERS AS DEFENDENTS, AND TO REVISE PROCEDURES FOR APPEALS OF CLAIM DENIALS; AMENDING CODIFIED ORDINANCES SECTION 14-305(c) TO ADD HIPAA SPECIAL ENROLLMENT RIGHTS TO THE BOROUGH'S CAFETERIA PLAN PERMITTING CHANGES IN ELECTIONS DURING A PLAN YEAR; AMENDING CODIFIED ORDINANCES SECTION 21-2002(b) TO INCREASE THE FEE FOR A ZONING PERMIT TO FIFTY DOLLARS ($50.00); AND AMENDING CODIFIED ORDINANCES SECTION 41-501 TO REMOVE THE NO PARKING RESTRICTION ON THE EASTERLY SIDE OF WALNUT STREET FOR THE FIRST 88 FEET SOUTH OF THIRD STREET.

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

WHEREAS, Borough Council desires to increase the fee for a zoning permit from $40.00 to $50.00; and

WHEREAS, Borough Council, upon the request of the adjoining property owner and with the recommendation of the Chief of Police, desires to eliminate the existing no parking zone on the easterly side of Walnut Street for the first 88 feet south of Third Street; and

WHEREAS, on January 7, 2015, 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 January 14, 2015;

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 § 12-403(d) (relating to Personnel Policies—Benefits—Health & Hospitalization—Working Spouses) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 12-403 Health & Hospitalization.

* * *

(d) Working Spouses. Notwithstanding anything to the contrary in this Section, no health coverage may be elected or provided for any period after December 31, 2014 with respect to a spouse of a full-time Borough employee for any month in which such spouse is eligible to participate as an employee in a group health plan sponsored by another employer, *unless* ~~(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 must provide, from time to time upon

request, proof that the spouse is not employed, or, if employed, that the spouse 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~~.

* * *

SECTION 2. Codified Ordinances § 14-305(c) (relating to Cafeteria Plan—Election of Optional Benefits—Revocation or Change of Election by the Participant During the Plan Year—Special Enrollment Rights) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 14-305 Revocation or Change of Election by the Participant During the Plan Year.

* * *

(c) Special Enrollment Rights. ~~Since none of the plans under this Plan are subject to Code § 9801(f) (relating to HIPAA special enrollment rights), since those provisions do not apply to a governmental plan (Code § 9831(a)), and also since the benefits under the Medical Expense Reimbursement Plan are "excepted benefits," a Participant may not revoke an election and file a new election under Treas. Regs. § 1.125-4(b) with respect to special enrollment rights.~~ In the case of coverage under the Health Plan, a Participant may revoke an election and file a new election for the balance of the Plan Year as follows, all in accordance with the provisions regarding special enrollment rights and special enrollment periods under Code § 9801(f), Public Health Service Act § 2701(f), 42 U.S.C. § 300gg-3(f), Treas. Regs. § 54.9801-6, and 45 CFR § 146.117:

(1) Certain Individuals Who Lose Coverage.

(A) When Participant Loses Coverage. A new election for coverage under the Health Plan may be filed to add coverage for a Participant and/or the spouse and/or any dependent(s) of a Participant) if—

(I) the Participant, and the spouse and/or dependents to be added, are otherwise eligihle to enroll in the Health Plan;

(II) the Participant is either already enrolled in the Health Plan or is to be added under the new election;

(III) when the last election for coverage under the Health Plan was offered, the Participant had coverage under any group health plan or health insurance coverage;

(IV) the Participant satisfies one of the conditions for special enrollment under subparagraph (C); and

(V) the Participant files the new election within thirty (30) days after the applicable event under subparagraph (C).

(B) When Spouse or Dependent Loses Coverage. A new election for coverage under the Health Plan may be filed to add coverage for the Participant and/or a Qualifying Dependent (defined as either the spouse or a specifically identified dependent of the Participant) if—

(I) the Qualifying Dependent and the Participant are otherwise eligihle to enroll in the Health Plan;

(II) the Participant is either already enrolled in the Health Plan or is to be added under the new election;

(III) when the last election for coverage under the Health Plan was offered, the Qualifying Dependent had coverage under any group health plan or health insurance coverage;

(IV) the Qualifying Dependent satisfies one of the conditions for special enrollment under subparagraph (C); and

(V) the Participant files the new election within thirty (30) days after the applicable event under subparagraph (C).

(C) Conditions for Special Enrollment.

(I) Loss of Eligiblity for Coverage. A person satisfies the conditions of this subparagraph (C) if the person has coverage that is not COBRA continuation coverage and that coverage is terminated as a result of loss of eligibility, regardless of whether the individual is eligible for or elects COBRA continuation coverage. For purposes of this clause (I), "loss of eligibility" *does not* include a loss due to the failure of the person to pay premiums on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the coverage), but *does* include, without being limited to—

(i) loss of eligibility for coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the coverage), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;

(ii) in the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(iii) in the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual; and

(iv) a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(II) Termination of Employer Contributions. A person satisfies the conditions of this subparagraph (C) if the person has coverage that is not COBRA continuation coverage and employer contributions toward the person's coverage terminate. Employer contributions include contributions by any current or former employer that was contributing to coverage for the person.

(III) Exhaustion of COBRA Continuation Coverage. A person satisfies the conditions of this subparagraph (C) if the person has coverage that is COBRA continuation coverage and that COBRA continuation coverage is exhausted (as defined in Treas. Regs. § 54-9801-2 and 45 CFR § 144.103).

(2) New Spouse of a Participant. A new election for coverage under the Health Plan may be filed to add coverage for a Participant and/or the spouse of a Participant if—

(A) the Participant and any spouse to be added to the coverage are otherwise eligihle to enroll in the Health Plan;

(B) the Participant is either already enrolled in the Health Plan or is to be added under the new election;

(C) the spouse has just become the spouse of the Participant; and

(D) the Participant files the new election within thirty (30) days after the date of the marriage.

(3) New Dependent of a Participant. A new election for coverage under the Health Plan may be filed to add coverage for a Participant, the spouse of a Participant, and/or a Qualifying Dependent (defined as a specifically identified dependent of the Participant), if—

(A) the Participant and any spouse and/or Qualifying Dependent to be added to the coverage are otherwise eligihle to enroll in the Health Plan;

(B) the Participant is either already enrolled in the Health Plan or is to be added under the new election;

(C) the Qualifying Dependent has just become a dependent of the Participant through marriage, birth, adoption, or placement for adoption; and

(D) the Participant files the new election within thirty (30) days after the date of the marriage, birth, adoption, or placement for adoption.

Notwithstanding subsection (*l*)(1) of this § 14-305, in the case where a Qualifying Dependant has just become a dependent of the Participant through birth, adoption, or placement for adoption, the new election for Health Plan coverage under this paragraph (3) shall be effective as of the date of the birth, adoption, or placement for adoption.

(4) Special Rules Relating to Medicaid or CHIP.

(A) When Participant Loses Coverage or Becomes Eligible for Assistance. A new election for coverage under the Health Plan may be filed to add coverage for a Participant and/or the spouse and/or any dependent(s) of a Participant) if—

(I) the Participant, and the spouse and/or dependents to be added, are otherwise eligihle to enroll in the Health Plan;

(II) the Participant is either already enrolled in the Health Plan or is to be added under the new election;

(III) either—

(i) the Participant has coverage under a Medicaid/CHIP plan and that coverage is terminated as a result of loss of eligibility for such coverage; or

(ii) the Participant becomes eligible for assistance, with respect to coverage under the Health Plan, under a Medicaid/CHIP plan; and

(IV) the Participant files the new election within sixty (60) days after the date of termination of the Medicaid/CHIP plan coverage or the date the Participant is determined to be eligible for assistance under a Medicaid/CHIP plan, as the case may be.

(B) When Spouse or Dependent Loses Coverage or Becomes Eligible for Assistance. A new election for coverage under the Health Plan may be filed to add coverage for the Participant and/or a Qualifying Dependent (defined as either the spouse or a specifically identified dependent of the Participant) if—

(I) the Qualifying Dependent and the Participant are otherwise eligihle to enroll in the Health Plan;

(II) the Participant is either already enrolled in the Health Plan or is to be added under the new election;

(III) either—

(i) the Qualifying Dependent has coverage under a Medicaid/CHIP plan and that coverage is terminated as a result of loss of eligibility for such coverage; or

(ii) the Qualifying Dependent becomes eligible for assistance, with respect to coverage under the Health Plan, under a Medicaid/CHIP plan; and

(IV) the Participant files the new election within sixty (60) days after the date of termination of the Medicaid/CHIP plan coverage or the date the Qualiyfing Dependent is determined to be eligible for assistance under a Medicaid/CHIP plan, as the case may be.

(C) Definition of Medicaid/CHIP Plan. For purposes of this paragraph (4), the term "Medicaid/CHIP Plan" means a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act.

* * *

SECTION 3. Codified Ordinances § 14-305(e) (relating to Cafeteria Plan—Election of Optional Benefits—Revocation or Change of Election by the Participant During the Plan Year—Medicare or Medicaid Entitlement) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 14-305 Revocation or Change of Election by the Participant During the Plan Year.

* * *

(e) Medicare or Medicaid Entitlement. In the case of coverage under the Health Plan, a Participant may revoke an election for the balance of the Plan Year and file a new election in order to cancel or reduce such coverage for the Participant, the Participant's spouse, or any covered dependent of the Participant to the extent that ~~the~~ that Participant, spouse, or dependent becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). The right to revoke an election and file a new election to cancel or reduce coverage under the Health Plan does *not* arise when a person becomes entitled to coverage under Title XXI of the Socrial Security Act (CHIP). In addition, if the Participant, the Participant's spouse, or any eligible dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election for the balance of the Plan Year to commence or increase coverage under the Health Plan for that Participant, spouse, or dependent (*provided* that the Participant is either already enrolled in the Health Plan or is to be added under the new election).

SECTION 4. Codified Ordinances § 14-305(m) (relating to Cafeteria Plan—Election of Optional Benefits—Revocation or Change of Election by the Participant During the Plan Year—Dependent) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 14-305 Revocation or Change of Election by the Participant During the Plan Year.

* * *

(m) Dependent. For purposes of this § 14-305, the term "dependent" means a person who is either—

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

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

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

SECTION 5. Codified Ordinances § 20-108 (relating to Medical Expense Reimbursement Plan—Title, Establishment, and General Definitions—Dependent) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20-108 Dependent.

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

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

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

SECTION 6. Codified Ordinances § 20-205 (relating to Medical Expense Reimbursement Plan—Participation and Level of Coverage—Continuation of Coverage) is amended by amending subsection (b) as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20-205 Continuation of Coverage.

* * *

(b) COBRA Continuation Coverage.

(1) Federal 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). In addition, under Treas. Regs. § 54.4980B-2 (Q&A 8(d)), COBRA continuation coverage in this Plan is not required after the Plan Year of the qualifying event, and under Treas. Regs. § 54.4980B-2 (Q&A 8(e)), COBRA continuation coverage in this Plan is not required for the Plan Year of the qualifying event beyond what is provided under subsection (a) of this § 20-205. 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 periodic premiums equal to the current Coverage Amount (without reduction for any reimbursements previously paid) divided by the portion of the Plan Year for which a particular premium payment provides continuation coverage.

(2) 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 periodic premiums equal to the current Coverage Amount (without reduction for any reimbursements previously paid) divided by the portion of the Plan Year for which a particular premium payment provides continuation coverage.

SECTION 7. Codified Ordinances § 20A-108 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Title, Establishment, and General Definitions—Dependent) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 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~~ except that any child to whom Code § 152(e) applies (relating to special rule for divorced parents) shall be treated as a "Dependent" of both parents; ~~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~~.~~ ; or

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

SECTION 8. Codified Ordinances § 20A-121 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Title, Establishment, and General Definitions—Qualifying Medical Care Expenses) is amended by amending subsections (a) and (b) as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20A-121 Qualifying Medical Care Expenses.

(a) In General. Except as provided otherwise in this § ~~20A-116~~ 20A-121, the term "Qualifying Medical Care Expenses" means expenses incurred by a Participant or his/her Covered Family Member, for Medical Care of the Participant during the time he/she is a Participant or for Medical Care of a Participant's Covered Family Member during the time he/she is a Covered Family Member, and which are applied to a deductible under the Primary Health Plan 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 § ~~20A-116~~ 20A-121, the term "Medical Care" shall mean amounts paid (within the meaning of Code § 213(d) and the regulations and rulings thereunder):

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SECTION 9. Codified Ordinances § 20A-405(b) (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Benefits—HRA Deductibles—Family Deductible) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20A-405 HRA Deductibles.

* * *

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

SECTION 10. Codified Ordinances Chapter 20A, Article V (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Claims Procedure) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

Article V — Claims Procedure

§ 20A-501 Filing a Claim.

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

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

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

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

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

(d) an explanation of the Plan's claim procedure, including the opportunity for review, applicable time limits, and how to initiate an review and appeal under ~~§ 20A-503~~ the following provisions of this Article~~.~~ ;

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

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

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

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

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

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

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

§ 20A-503 Internal 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~~ for benefits. A claimant may request reasonable access to and copies of all documents, records, and other information relevant to the claim, which

shall be provided to the claimant free of charge. The 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) Medical Judgment. If the review by the Claims Administrator involves a determination based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment or other item is experimental, investigational, or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the review will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the review, nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the review.

~~(b)~~ **(c) 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 (except that the 30 day period for making a decision shall not be extended).

§ 20A-504 Appeal to the Administrator.

~~(c)~~ **(a)** ~~**Appeal to the Administrator**~~ **In General.** In lieu of an external review under § 20A-505, ~~A~~ 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)~~ § 20A-503 within 60 days after the receipt of a notice of denial under ~~subsection (b)~~ § 20A-503, 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)~~ § 20A-503.

~~(d)~~ (b) 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)~~ § 20A-503; *and*

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

~~(e)~~ (c) Decision. The Administrator shall issue a written decision at the conclusion of a review under ~~subsections (c) and (d)~~ this Section within ~~30~~ 60 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)~~ (d) Compliance with Local Agency Law. All reviews by the Administrator under this § ~~20A-503~~ 20A-504 shall comply with the provisions of the Local Agency Law, 2 PA. CONS. STAT. § 551 *et seq*., and appeals of the decision may be made to the courts in accordance with that Law.

§ 20A-505 External Review.

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

(b) Federal Procedure. If this Plan is not subject to a Pennsylvania external review procedure under subsection (a), then it must provide an effective Federal external review process under 45 CFR § 147.136(d). Until further information is provided by the regulatory agencies, a Federal external review must be filed with the external reviewer within four (4) months of the date the claimant was served with the decision under § 20A-503, or the claimant shall lose the right to an external review and appeal. The Plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the Plan, the claimant provided all of the necessary information to process the external review, and that the claimant has exhausted the internal appeals process. The Plan must provide the claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan will permit the claimant to perfect the external review request within the four (4) month period or, if later, 48 hours after receipt of the notice. The Plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify the clamaint and the Plan Administrator of its decision within 45 days after its receipt of the request for external review. The external reviewer's decision is binding on the parties unless other State or Federal law remedies are available. Notwithstanding anything to the contrary in this subsection (b), until further requirements by the regulatory agencies, this Plan shall comply with the U.S. Department of Labor's private accredited independent review organization (IRO) process described in EBSA Technical Release 2010-01, dated August 23, 2010, as modified, under U.S. Department of Health and Human Services Technical Guidance issued July 22, 2011.

SECTION 11. Codified Ordinances § 20B-108 (relating to Health Reimbursement Arrangement for Police Employees—Title, Establishment, and General Definitions—Dependent) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 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~~ except that any child to whom Code § 152(e) applies (relating to special rule for divorced parents) shall be treated as a "Dependent" of both parents; ~~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~~.~~ ; or

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

SECTION 12. Codified Ordinances § 20B-121 (relating to Health Reimbursement Arrangement for Police Employees—Title, Establishment, and General Definitions—Qualifying Medical Care Expenses) is amended by amending subsections (a) and (b) as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20B-121 Qualifying Medical Care Expenses.

(a) In General. Except as provided otherwise in this § ~~20B-116~~ 20B-121, the term "Qualifying Medical Care Expenses" means expenses

incurred by a Participant or his/her Covered Family Member, for Medical Care of the Participant during the time he/she is a Participant or for Medical Care of a Participant's Covered Family Member during the time he/she is a Covered Family Member, and which are applied to a deductible under the Primary Health Plan 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~~ 20B-121, the term "Medical Care" shall mean amounts paid (within the meaning of Code § 213(d) and the regulations and rulings thereunder):

* * *

* * *

SECTION 13. Codified Ordinances § 20B-405(b) (relating to Health Reimbursement Arrangement for Police Employees—Benefits—HRA Deductibles—Family Deductible) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20B-405 HRA Deductibles.

* * *

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

SECTION 14. Codified Ordinances Chapter 20B, Article V (relating to Health Reimbursement Arrangement for Police Employees—Claims Procedure) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

Article V — Claims Procedure

§ 20B-501 Filing a Claim.

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

§ 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). (However, this 30-day period may be extended one time by the Claims Administrator for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date hy which the Claims Administrator expects to render a

decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. In that event, the time period for processing the claim shall not begin to run again until the information is received from the claimant or his/her authorized representative,) Any notice of denial shall contain, in a manner calculated to be understood by the claimant—

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

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

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

(d) an explanation of the Plan's claim procedure, including the opportunity for review, applicable time limits, and how to initiate an review and appeal under ~~§ 20B 503~~ the following provisions of this Article~~.~~ ;

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

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

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

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

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

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

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

§ 20B-503 Internal 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~~ for benefits. A claimant may request reasonable access to and copies of all documents, records, and other information relevant to the claim, which shall be provided to the claimant free of charge. The 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) Medical Judgment. If the review by the Claims Administrator involves a determination based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment or

other item is experimental, investigational, or not medically necessary or appropriate), a health care professional with the appropriate training and experience in the field of medicine at issue in the review will be appointed. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the review, nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the review.

~~(b)~~ **(c) 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 (except that the 30 day period for making a decision shall not be extended).

§ 20B-504 Appeal to the Administrator.

~~(c)~~ **(a) ~~Appeal to the Administrator~~ In General.** In lieu of an external review under § 20B-505, ~~A~~ 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)~~ § 20B-503 within 60 days after the receipt of a notice of denial under ~~subsection (b)~~ § 20B-503, 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)~~ § 20B-503.

~~(d)~~ **(b) 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)~~ § 20B-503; *and*

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

~~(e)~~ **(c) Decision.** The Administrator shall issue a written decision at the conclusion of a review under ~~subsections (c) and (d)~~ this Section within ~~30~~ 60 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)~~ **(d) Compliance with Local Agency Law.** All reviews by the Administrator under this § ~~20B-503~~ 20B-504 shall comply with the provisions of the Local Agency Law, 2 PA. CONS. STAT. § 551 *et seq*., and appeals of the decision may be made to the courts in accordance with that Law.

§ 20B-505 External Review.

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

(b) Federal Procedure. If this Plan is not subject to a Pennsylvania external review procedure under subsection (a), then it must provide an effective Federal external review process under 45 CFR § 147.136(d). Until further information is provided by the regulatory agencies, a Federal external review must be filed with the external reviewer within four (4) months of the date the claimant was served with the decision under § 20B-503, or the claimant shall lose the right to an external review and appeal. The Plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the Plan, the claimant provided all of the necessary information to process the external review, and that the claimant has exhausted the internal appeals process. The Plan must provide the

claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan will permit the claimant to perfect the external review request within the four (4) month period or, if later, 48 hours after receipt of the notice. The Plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify the clamaint and the Plan Administrator of its decision within 45 days after its receipt of the request for external review. The external reviewer's decision is binding on the parties unless other State or Federal law remedies are available. Notwithstanding anything to the contrary in this subsection (b), until further requirements by the regulatory agencies, this Plan shall comply with the U.S. Department of Labor's private accredited independent review organization (IRO) process described in EBSA Technical Release 2010-01, dated August 23, 2010, as modified, under U.S. Department of Health and Human Services Technical Guidance issued July 22, 2011.

SECTION 15. Codified Ordinances § 21-2002(b) (relating to Zoning—Administration, Fees, Permits, and Penalties—Fees, Charges, and Expenses—Zoning Permits) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 21-2002 Fees, Charges, and Expenses

* * *

(b) Zoning Permits. The fee for a zoning permit under § 21-2003 (relating to Zoning Permits Required) shall be ~~Forty~~ Fifty Dollars (~~$40.00~~ $50.00). This fee is in addition to the fees for all other permits which may be required in connection wit the activity or use which is the subject of the

zoning permit, including but not limited to building permits and other permits under Chapter 30 (relating to Uniform Construction Code).

* * *

SECTION 16. Codified Ordinances § 41-501 (relating to Traffic Control—No Parking Zones—No Parking at Any Time) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 41-501 No Parking at Any Time.

No part of a vehicle shall be parked at any point within the following locations at any time:

	Street	Side	From:	To:
* * *				
~~54.~~	~~Walnut Street~~	~~Easterly~~	~~Southern curbline of Third Street~~	~~The point eighty-eight (88) feet south of the starting point~~

SECTION 17. The Borough shall remove the official traffic control devices installed under Codified Ordinances § 41-104 (relating to Traffic Control—General Provisions—Official Signs) with respect to the no parking zone formerly ordained under Codified Ordinances § 41-501(54) and deleted by Section 16 of this Ordinance.

DULY ORDAINED and **ENACTED** by the Borough Council of the Borough of Alburtis, this 14th day of January, 2015, in lawful session duly assembled.

BOROUGH COUNCIL
BOROUGH OF ALBURTIS

_____
Steven R. Hill, President

Attest:

_____
Sharon Trexler, Executive Secretary

AND NOW, this 14th day of January, 2015, the above Ordinance is hereby APPROVED.

_____
Kathleen Palmer, Mayor