BOROUGH OF ALBURTIS
LEHIGH COUNTY, PENNSYLVANIA

Ordinance No. 526

(Duly Adopted January 28, 2015)

AN ORDINANCE CREATING THE POSITION OF BOROUGH MANAGER AND TRANSFERRING TO THAT POSITION THE POWERS, DUTIES, RESPONSIBILITIES AND FUNCTIONS CURRENTLY PERFORMED BY THE EXECUTIVE SECRETARY; AMENDING CODIFIED ORDINANCES SECTION 7-401(g) TO INCREASE THE CERTIFIED LETTER FEE FROM A FLAT SIX DOLLARS ($6.00) TO ONE HUNDRED TEN PERCENT (110%) OF THE FEE CHARGED BY THE U.S. POSTAL SERVICE; AMENDING THE MEDICAL EXPENSE REIMBURSEMENT PLAN AND THE HEALTH REIMBURSEMENT ARRANGEMENTS TO ELABORATE UPON THE REQUIREMENTS IMPOSED TO COMPLY WITH THE PRIVACY, SECURITY, AND ADMINISTRATIVE SIMPLIFICATION RULES UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA); AND AMENDING THE HEALTH REIMBURSEMENT ARRANGEMENTS TO REVISE PROCEDURES FOR APPEALS OF CLAIM DENIALS.

WHEREAS, Borough Council believes that the powers, duties, responsibilities, and functions currently performed by the Executive Secretary are typically performed in other boroughs and townships by an officer with the title of "Manager"; and

WHEREAS, Borough Council believes that the title "Executive Secretary" lacks the prestige and status appropriate to the Borough's managerial, supervisor, and administrative leader, and that this situation has intangible negative effects for both the Borough in general and the Executive Secretary in particular in dealing with the public and other municipalities and governmental entities; and

WHEREAS, Borough Council therefore desires to create the position of Borough Manager and transfer to that position the powers, duties, responsibilities, and functions currently performed by the Exective Secretary; and

WHEREAS, Borough Council desires to increase the fee for a certified letter from a flat $6.00 to 110% of the fee charged by the U.S. Postal Service; and

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

WHEREAS, on January 21, 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 28, 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 § 12-603 (relating to Personnel Policies—Employment Duties—Executive Secretary) is amended by amending the title and introductory paragraph (prior to subsection (a)) as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 12-603 ~~Executive Secretary~~ Borough Manager.

Effective ~~January 1, 2005, the position formerly known as the Borough Secretary shall be known as and granted the title of "Executive Secretary."~~ January 28, 2015, Council hereby creates the position of Borough Manager in accordance with § 1141 of the Borough Code, 8 PA. CONS. STAT. § 1141. The Borough Manager shall be elected by a vote of a majority of all members of Council, and shall serve at the pleasure of Council, subject to any contractual rights that may arise under an employment agreement entered into by Council and the Borough Manager which satisfies the requirements of Borough Code § 1142(b), 8 PA. CONS. STAT. § 1142. The Borough Manager shall succeed to all powers and obligations of the position formerly titled "Executive Secretary" under any contract of the Borough. In addition to all other ~~required duties~~ powers, duties, responsibilities, and functions of the Borough Manager set forth in the Codified Ordinances, the ~~Executive Secretary~~ Borough Manager shall:

* * *

SECTION 2. Codified Ordinances Chapter 1, Article II (relating to Codified Ordinances—Definitions) is amended by adding the following new § 1-203.1 after existing § 1-203:

§ 1-203.1 Manager.

The term "Manager" or "Borough Manager" shall mean the Borough Manager of the Borough.

SECTION 3. Codified Ordinances § 1-206 (relating to Codified Ordinances—Definitions—Secretary) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 1-206 Secretary.

The term "Secretary"~~,~~ or "Borough Secretary"~~, or "Executive Secretary"~~ shall mean the ~~Executive Secretary~~ Borough Manager of the Borough, acting in his/her role as the *ex officio* Secretary under § 12-603(p).

SECTION 4. Codified Ordinances § 11-104(a) (relating to Salaries and Compensation—In General—Administration—Executive Secretary) is amended by amending the title and paragraph (13) as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 11-104 Administration.

(a) ~~Executive Secretary~~ Borough Manager.

* * *

(13) 2015. The annual salary of the ~~Executive Secretary~~ Borough Manager for the year 2015 (including service as the Exectuvie Secretary through January 28, 2015) shall be $53,612.

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SECTION 5. Codified Ordinances § 13-205 (relating to Police Civil Service—Definitions—Borough Secretary) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 13-205 Borough ~~Secretary~~ Manager.

The term "Borough ~~Secretary~~ Manager" shall mean the ~~Executive Secretary~~ Borough Manager of the Borough.

SECTION 6. Codified Ordinances §§ 1-107, 1-108, 7-402(c), 12-201(a), 12-205(d), 12-503, 12-507, 12-508(e)(1)(A), 12-702, 13-503, 13-508, 13-804(a), 21-303(a), 21-303(d), 21-1505, 21-1903(b)(3), 21-1903(b)(5), 21-2006, 25-238, 30-106, 31-303, 31-401, 41-805, 53-302, 53-307, 56-102, 56-103, 56-104, 64-103, 64-201(a), 64-201(b), 64-509, 64-609(e), 64-701(a), 64-702(b), 64-701(c), 64-701(d), 64-702(a), 64-702(b), 64-702(d), 64-702(e), 64-703, 64-704, 64-706(a), 65-506(d), 65-1210(e)(1), 65-1501(b)(1), 65-1502(b), 67-305, 67-602, 67-603, 67-703(d), 67-704, 67-802(b), 69-205(b), 69-205(c), 87-304, 89-101, 89-201, 87-104, 97-105, 97-106, 97-112, and 97-113 shall be amended by replacing the term "Borough Secretary" with "Borough Manager" every time the former term currently appears in such provisions.

SECTION 7. Codified Ordinances §§ 15-103 (first sentence), 24-412(a), 31-102, 32-102, 35-102, 65-304(c), 64-304(d), 65-1601(b), and 65-1602(c) shall be amended by replacing the term "Secretary" with "Borough Manager" every time the former term currently appears in such provisions.

SECTION 8. Codified Ordinances §§ 22-408 and 22-509 shall be amended by replacing the term "Secretary" with "the Borough Manager" every time the former term currently appears in such provisions.

SECTION 9. Codified Ordinances § 80-502 shall be amended by replacing the term "secretary of the Borough" with "Borough Manager" every time the former term currently appears in such provisions.

SECTION 10. Codified Ordinances §§ 30-211(b), 69-301, 83-301, and 89-103(a)(1) shall be amended by replacing the term "Borough Executive Secretary" with "Borough Manager" every time the former term currently appears in such provisions.

SECTION 11. Codified Ordinances §§ 3-101, 9-204, 12-201(b), 12-202(b), 12-203(a), 12-203(b), 12-301(a)(10), 12-301(b), 12-302(c)(3), 12-302(e), 12-304(c), 12-304(d), 12-501, 12-508(b)(1), 12-508(c)(1), 12-601, 12-603(n), 12-603(o), 12-604(e), 12-605(e), 30-211(b), 38-105, 46-109(c), 47-105(c), 53-309(b), 53-309(c), 53-403(c), 53-

502(d), 56-106(b), 56-106(c), 56-302(b), 56-302(c), 56-602(b), 56-602(c), 61-107(b), 61-107(c), 64-110(b), 64-110(c), 65-308(d), 67-701(h)(3), 67-901(e), 69-402(b), 69-402(c), 73-105(b), 73-105(c), 75-103, 76-108(b), 76-108(c), 76-203(c), 76-203(d), 89-103(b), 89-103(c), 89-203(b), 89-203(c), 91-102(c), 91-102(d), 92-107(b), 92-107(c), 93-204(b), and 93-204(c) shall be amended by replacing the term "Executive Secretary" with "Borough Manager" every time the former term currently appears in such provisions.

SECTION 12. Codified Ordinances § 7-401(g) (relating to Departments—Administration—Miscellaneous Fees—Certified Letterl) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 7-401 Miscellaneous Fees.

* * *

(g) Centified Letters. The fee for a certified letter shall be ~~Six Dollars ($6.00)~~ one hundred ten percent (110%) of the fee charged by the U.S. Postal Service.

* * *

SECTION 13. Codified Ordinances Chapter 20 (relating to Medical Expense Reimbursement Plan) is amended by adding the following new Article VIIIA:

Article VIIIA — HIPAA Privacy and Security Practices

§ 20-821 In General.

This Plan is not subject to the administrative simplification provisions, the privacy rule, or the securcity rule of~~, 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 Executive Secretary~~ because it has fewer than fifty (50) participants (as defined in section 3(7) of ERISA, 29 U.S.C. § 1002(7) and is self-administered by the Employer. *See* 45 CFR §§ 160.102(a) and 160.103 (definitions of health plan and group health plan).

SECTION 14. Codified Ordinances § 20A-105 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Title, Establishment, and General Definitions—Claims Administrator) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20A-105 ~~Claims Administrator.~~ [RESERVED]

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

SECTION 15. Codified Ordinances § 20A-402 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Benefits—Application for Reimbursement) is amended by amending subsections (a) and (b) as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 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.

* * *

SECTION 16. Codified Ordinances § 20A-409 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Benefits—Fraudulent Claims) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 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~~ Employer 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.

SECTION 17. 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;

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

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

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

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

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

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

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

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

§ 20A-503 Internal ~~Review~~ Appeal of Denial.

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

(b) Medical Judgment. If the ~~review by~~ internal appeal before 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~~ appeal, nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the ~~review~~ appeal.

(c) Final Decision by ~~Claims~~ Administrator. If the ~~Claims~~ Administrator still denies the claim following ~~a review~~ an appeal 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). In addition, the denial shall include the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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

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

~~**§ 20A-504 Appeal to the Administrator.**~~

~~**(a) In General.** In lieu of an external review under § 20A-505, a claimant may petition the Administrator in writing for a review of the final denial of any claim by the Claims Administrator under § 20A-503 within 60 days after the receipt of a notice of denial under § 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 § 20A-503.~~

~~**(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 § 20A-503; *and*~~

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

~~**(c) Decision.** The Administrator shall issue a written decision at the conclusion of a review under this Section within 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.~~

~~**(d) Compliance with Local Agency Law.** All reviews by the Administrator under this 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~~ 20A-504 External Review.

(a) State Procedure. If this Plan is subject to a Pennsylvania external review procedure that applies to and is binding on this Plan,

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

(b) Federal Procedure. If this Plan is not subject to a Pennsylvania external review procedure under subsection (a), then it must provide an effective Federal external review process under 45 CFR § 147.136(d) (except with respect to a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a person fails to meet the requirements for eligibilithy under the terms of the Plan). Until further information is provided by the regulatory agencies, a Federal external review must be filed by the claimant or his/her authorized representative with the external reviewer within four (4) months of the date the claimant was served with the decision under § 20A-503, or the claimant shall lose the right to an external review and appeal. The Plan must complete a preliminary review within five (5) business days upon receipt of the external review request to determine if the claimant was covered under the Plan, the claimant provided all of the necessary information to process the external review, and that the claimant has exhausted the internal appeals process. The Plan must provide the claimant written notice of its preliminary review determination within one (1) business day after completing its review. If the request is complete, but not eligible for external review, the notice must state the reasons for the ineligibility and provide EBSA contact information. If the request is incomplete, the notice must describe the information or materials needed to complete the request. The Plan will permit the claimant to perfect the external review request within the four (4) month period or, if later, 48 hours after receipt of the notice. The Plan must assign an accredited Independent Review Organization (IRO) to perform the external review. The external reviewer must notify the 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. The Plan must provide any benefits (including making payment on the claim) pursuant to the final

external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. Notwithstanding anything to the contrary in this subsection (b), until further requirements by the regulatory agencies, this Plan shall comply with the U.S. Department of Labor's private accredited independent review organization (IRO) process described in EBSA Technical Release 2010-01, dated August 23, 2010, as modified, under U.S. Department of Health and Human Services Technical Guidance issued July 22, 2011. The Administrator, on behalf of the Plan, shall contract with at least three IROs and must rotate assignments among the IROs.

§ 20A-505 Adverse Benefit Determinations.

The provisions of this Article V with respect to the denial, appeal, and review of a claim shall also apply to all other adverse benefit determinations as defined in 29 CFR § 2560.503-1, as well as any rescission of coverage, as described in 45 CFR § 128, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

SECTION 18. Codified Ordinances § 20A-601 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Administration—In General) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20A-601 In General.

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

SECTION 19. Codified Ordinances § 20A-604(b) (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Administration—Powers and Duties—Delegation) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20A-602 Powers and Duties.

* * *

(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 discretion 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.~~

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SECTION 20. Codified Ordinances § 20A-606 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—Administration—Facility of Payment) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20A-606 Facility of Payment.

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

SECTION 21. Codified Ordinances § 20A-901 (relating to Health Reimbursement Arrangement for Nonuniformed Employees—HIPAA Privacy and Security Practices—In General) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 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~~ HIPAA, including the administrative simplification provisions as set forth in 45 CFR Part 160 and Part 162, 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, the provisions that govern notification in the case of breach of unsecured Protected Health Information as set forth in 45 CFR Part 160 and Part 164, Subparts A and D, 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 ~~Exeecutuive Secretary~~ Manager.

SECTION 22. Codified Ordinances Chapter 20A, Article IX (relating to Health Reimbursement Arrangement for Nonuniformed Employees—HIPAA Privacy and Security Practices) is amended by adding the following new sections after existing § 20A-901:

§ 20A-902 Definitions.

For purposes of this Article IX, the terms defined in this Section shall have the meanings indicated herein, whether with or without initial capital letters, unless the context in which they are used clearly indicates a different meaning:

(a) Covered Individual. The term "Covered Individual" shall mean a Participant or Covered Family Member.

(b) Electronic Protected Health Information. The term "Electronic Protected Health Information" shall have the same meaning as described in 42 CFR § 160.103, and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment inormation and Summary Health Information.

(c) HIPAA. The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder from time to time,

(d) Protected Health Information. The term "Protected Health Information" shall have the same meaning as described in 45 CFR § 160.103, and generally includes individually identifiable health information held by, or or behalf of, the Plan.

(e) Summary Health Information. The term "Summary Health Information" means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor ha provided health benefits under a health plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(f) Other Terms. Other terms used in this Article which are not defined in this Chapter but which have a definite meaning under HIPAA shall have the same meaning as when used in HIPAA, unless the context in which they are used clearly indicates a different meaning.

§ 20A-903 Employer's Certification of Compliance.

The Employer hereby certifies to the Plan and the Administrator that the Plan document (this Chapter 20A) incorporates the provisions of 45 CFR § 164.504(f)(2)(ii), and the Employer hereby agrees to the conditions of disclosure set forth in this Article.

§ 20A-904 Permitted Disclosures to the Employer for Plan Administration Purposes.

(a) In General. Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer if the Employer will use or disclose such Protected Health Information only for Plan Administration Purposes.

(b) Plan Administration Purposes. For purposes of this Section, the term "Plan Administration Purposes" means administrative functions performed by the Employer on behalf of the Plan, such as making payment of claims as certified to the Employer by the Plan Administrator, payment of administrative fees, quality assurance, auditing, monitoring, and investigation of fraud, abuse, or unlawful acts related to the Plan, and reporting, disclosure, and other obligations that are required by law or specifically authorized by HIPAA or other applicable law, and contemplated by the notice of privacy practices distributed by the Plan in accordance with 45 CFR § 164.520. Plan Administrative Purposes do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by the Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article (including but not limited to § 20A-905) and the specifications and requirements of the applicable portions of the HIPAA implementing regulations at 45 CFR Parts 160 through 164.

§ 20A-905 Restrictions on the Employer's Use and Disclosure of Protected Health Information.

(a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by this Chapter or as required by law.

(b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the same restrictions, conditions, and security measures of this Chapter that apply to Employer with respect to the Protected Health Information.

(c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(d) Employer will report to the Plan and the Plan Administrator any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under this Chapter of which the Employer becomes aware.

(e) Employer will make Protected Health Information available to the Plan and the Plan Administrator or to the Covered Individual who is the subject of the information in accordance with 45 CFR § 164.524.

(f) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 CFR § 164.526.

(g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 CFR § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528, and will make available such information.

(h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the Plan available to the Plan, the Administrator, and the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164, Subpart E.

(i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, recevied from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) Employer will ensure that the adequate separate between the Plan and the Employer (*i.e.*, the "firewall") required in § 20A-907 and 45 CFR § 504(f)(2)(iii), is satisfied.

§ 20A-906 Other Disclosures to the Employer.

Nothing in this Article shall prohibit or in any way limit the Plan from disclosing a Covered Individual's Protected Health Information to the Employer where HIPAA permits such disclosure in the absence of the requirements of §§ 20A-904 and 20A-905, including, to the extent permitted by HIPAA, the disclosure of Protected Health Information:

(a) that is Summary Health Information, upon the request of the Employer for the purpose of modifying, amending, or terminating this Plan;

(b) on whether an individual is participating in the Plan; or

(c) pursuant to and in accordance with a valid individual authorization under the HIPAA Privacy Rule.

§ 20A-907 Adequate Separation Between the Employer and the Plan.

(a) Employees of the Employer to be Given Access to Information. Only the Borough Manager and the Borough Treasurer may be given access to a Covered Individual's Protected Healh Information received by the Employer from the Plan or a business associate servicing the Plan, except that members of Borough Council may be given access to the information described in § 20A-906(a) or (b).

(b) Purposes of Use. The persons identified in subsection (a) will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions specified in § 20A-904 that Employer provides for the Plan, or in accordance with permitted disclosures made under § 20A-906.

(c) Disciplinary Action. The persons identified in subsection (a) will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use

or disclosure of a Covered Individual's Protected Health Information in breach of or violation of or noncompliance with the provisions of this Article. Such disciplinary action may include one or more of the following to the extent not inconsistent with other applicable disciplinary policies: written or oral warning or reprimand, required additional training and education, limitations on or revocation of access to Protected Health Information, diminution of duties, suspension, probation, disqualification for bonus or other pay or promotion, demotion in pay or status, referral for criminal prosecution, a requirement to reimburse the Plan or Employer for damages, removal from position, or discharge.

§ 20A-908 Investigation of Incidents of Noncompliance.

If the Employer becomes aware of any issues relating to noncompliance with the requirements of this Article, the Epmolyer shall undertake an investigation to determine the extent, if any, of such noncompliance; the individuals, policies, practices, or procedures responsible for the noncompliance; and, to the extent feasible, appropriate means for curing or mitigating the effects of noncompliance and preventing such noncompliance in the future.

§ 20A-909 Security Measures for Electronic Protected Health Information.

The Borough Manager will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

§ 20A-910 Notification of Security Incidents.

The Employer will report to the Plan and the Administrator any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

SECTION 23. Codified Ordinances Chapter 20A, Article X (relating to Health Reimbursement Arrangement for Employees—Miscellaneous) is amended by amending §§ 20A-1001, 20A-1002, and 20A-1004 as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 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, or 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-1004 Information to be Furnished.

Participants shall provide the Employer~~,~~ and 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.

* * *

SECTION 24. Codified Ordinances § 20B-105 (relating to Health Reimbursement Arrangement for Police Employees—Title, Establishment, and General Definitions—Claims Administrator) is amended as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 20B-105 ~~Claims Administrator.~~ [RESERVED]

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

SECTION 25. Codified Ordinances § 20B-402 (relating to Health Reimbursement Arrangement for Police Employees—Benefits—Application for Reimbursement) is amended by amending subsections (a) and (b) as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 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.

* * *

SECTION 26. Codified Ordinances § 20B-409 (relating to Health Reimbursement Arrangement for Police Employees—Benefits—Fraudulent Claims) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 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~~ Employer 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.

SECTION 27. 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;

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

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

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

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

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

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

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

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

§ 20B-503 Internal ~~Review~~ Appeal of Denial.

(a) Petition. A claimant or his/her authorized representative may petition the ~~Claims~~ Administrator in writing for ~~a review~~ an internal appeal 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 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~~ appeal before 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~~ an internal appeal that does not afford deference to the initial adverse determination, and which is conducted by someone who is neither the individual who made the initial determination, nor the subordinate of such individual. If any new or additional information is considered, relied upon, or generated by or at the direction of the Plan or the Administrator in connection with the internal appeal, such evidence must be provided, free of charge, to the claimant as soon as possible and sufficiently in advance of the date by which the notice of final internal appeal determination is required to give the claimant a reasonable opportunity to respond prior to that date.

(b) Medical Judgment. If the ~~review by~~ internal appeal before 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~~ appeal, nor the subordinate of any such individual. Upon request, the claimant will be provided with the identification of any medical or vocational experts whose advice was sought in connection with the ~~review~~ appeal.

(c) Final Decision by ~~Claims~~ Administrator. If the ~~Claims~~ Administrator still denies the claim following ~~a review~~ an appeal 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). In addition, the denial shall include the following statement: "You and your plan may

have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

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

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

~~**§ 20B-504 Appeal to the Administrator.**~~

~~**(a) In General.** In lieu of an external review under § 20B-505, a claimant may petition the Administrator in writing for a review of the final denial of any claim by the Claims Administrator under § 20B-503 within 60 days after the receipt of a notice of denial under § 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 § 20B-503.~~

~~**(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 § 20B-503; *and*~~

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

~~**(c) Decision.** The Administrator shall issue a written decision at the conclusion of a review under this Section within 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.~~

~~**(d) Compliance with Local Agency Law.** All reviews by the Administrator under this 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~~ 20B-504 External Review.

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

(b) Federal Procedure. If this Plan is not subject to a Pennsylvania external review procedure under subsection (a), then it must provide an effective Federal external review process under 45 CFR § 147.136(d) (except with respect to a denial, reduction, termination, or failure to provide payment for a benefit based on a determination that a person fails to meet the requirements for eligibilithy under the terms of the Plan). Until further information is provided by the regulatory agencies, a Federal external review must be filed by the claimant or his/her authorized representative with the external reviewer within four (4) months of the date the claimant was served with the decision under § 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. The Plan must provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise. Notwithstanding anything to the contrary in this subsection (b), until further requirements by the regulatory agencies, this Plan shall comply with the U.S. Department of Labor's private accredited independent review organization (IRO) process described in EBSA Technical Release 2010-01, dated August 23, 2010, as modified, under U.S. Department of Health and Human Services Technical Guidance issued July 22, 2011. The Administrator, on behalf of the Plan, shall contract with at least three IROs and must rotate assignments among the IROs.

§ 20B-505 Adverse Benefit Determinations.

The provisions of this Article V with respect to the denial, appeal, and review of a claim shall also apply to all other adverse benefit

determinations as defined in 29 CFR § 2560.503-1, as well as any rescission of coverage, as described in 45 CFR § 128, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

SECTION 28. Codified Ordinances § 20B-601 (relating to Health Reimbursement Arrangement for Police Employees—Administration—In General) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20B-601 In General.

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

SECTION 29. Codified Ordinances § 20B-604(b) (relating to Health Reimbursement Arrangement for Police Employees—Administration—Powers and Duties—Delegation) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20B-602 Powers and Duties.

* * *

(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 discretion 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.~~

* * *

SECTION 30. Codified Ordinances § 20B-606 (relating to Health Reimbursement Arrangement for Police Employees—Administration—Facility of Payment) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 20B-606 Facility of Payment.

Whenever the ~~Administrator~~ Employer determines that a person entitled to receive any payment of a benefit or installment is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the ~~Administrator~~ Employer may make payments to such person, to his legal representative, to a relative, or to a friend of such

person for his benefit. Any payment of a benefit or installment in accordance with the provisions of this Section shall be a complete discharge from any liability for the making of such payment under the provisions of the Plan.

SECTION 31. Codified Ordinances § 20B-901 (relating to Health Reimbursement Arrangement for Police Employees—HIPAA Privacy and Security Practices—In General) is amended as follows (with deletions indicated by ~~strike-outs~~ and insertions indicated by double underlining):

§ 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~~ HIPAA, including the administrative simplification provisions as set forth in 45 CFR Part 160 and Part 162, 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, the provisions that govern notification in the case of breach of unsecured Protected Health Information as set forth in 45 CFR Part 160 and Part 164, Subparts A and D, 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 ~~Exeeeutuive Secretary~~ Manager.

SECTION 32. Codified Ordinances Chapter 20B, Article IX (relating to Health Reimbursement Arrangement for Police Employees—HIPAA Privacy and Security Practices) is amended by adding the following new sections after existing § 20B-901:

§ 20B-902 Definitions.

For purposes of this Article IX, the terms defined in this Section shall have the meanings indicated herein, whether with or without initial capital letters, unless the context in which they are used clearly indicates a different meaning:

(a) Covered Individual. The term "Covered Individual" shall mean a Participant or Covered Family Member.

(b) Electronic Protected Health Information. The term "Electronic Protected Health Information" shall have the same meaning as described in 42 CFR § 160.103, and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment inormation and Summary Health Information.

(c) HIPAA. The term "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations promulgated thereunder from time to time,

(d) Protected Health Information. The term "Protected Health Information" shall have the same meaning as described in 45 CFR § 160.103, and generally includes individually identifiable health information held by, or or behalf of, the Plan.

(e) Summary Health Information. The term "Summary Health Information" means information (1) that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor ha provided health benefits under a health plan; and (2) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

(f) Other Terms. Other terms used in this Article which are not defined in this Chapter but which have a definite meaning under HIPAA shall have the same meaning as when used in HIPAA, unless the context in which they are used clearly indicates a different meaning.

§ 20B-903 Employer's Certification of Compliance.

The Employer hereby certifies to the Plan and the Administrator that the Plan document (this Chapter 20B) incorporates the provisions of 45 CFR § 164.504(f)(2)(ii), and the Employer hereby agrees to the conditions of disclosure set forth in this Article.

§ 20B-904 Permitted Disclosures to the Employer for Plan Administration Purposes.

(a) In General. Unless otherwise permitted by law, the Plan may disclose a Covered Individual's Protected Health Information to the Employer if the Employer will use or disclose such Protected Health Information only for Plan Administration Purposes.

(b) Plan Administration Purposes. For purposes of this Section, the term "Plan Administration Purposes" means administrative functions performed by the Employer on behalf of the Plan, such as making payment of claims as certified to the Employer by the Plan Administrator, payment of administrative fees, quality assurance, auditing, monitoring, and investigation of fraud, abuse, or unlawful acts related to the Plan, and reporting, disclosure, and other obligations that are required by law or specifically authorized by HIPAA or other applicable law, and contemplated by the notice of privacy practices distributed by the Plan in accordance with 45 CFR § 164.520. Plan Administrative Purposes do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment-related functions. Any disclosure to and use by the Employer of a Covered Individual's Protected Health Information will be subject to and consistent with the provisions of this Article (including but not limited to § 20B-905) and the specifications and requirements of the

applicable portions of the HIPAA implementing regulations at 45 CFR Parts 160 through 164.

§ 20B-905 Restrictions on the Employer's Use and Disclosure of Protected Health Information.

(a) Employer will neither use nor further disclose a Covered Individual's Protected Health Information, except as permitted or required by this Chapter or as required by law.

(b) Employer will ensure that any agent, including any subcontractor, to which it provides a Covered Individual's Protected Health Information received from the Plan, agrees to the same restrictions, conditions, and security measures of this Chapter that apply to Employer with respect to the Protected Health Information.

(c) Employer will not use or disclose a Covered Individual's Protected Health Information for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of Employer.

(d) Employer will report to the Plan and the Plan Administrator any use or disclosure of a Covered Individual's Protected Health Information that is inconsistent with the uses and disclosures allowed under this Chapter of which the Employer becomes aware.

(e) Employer will make Protected Health Information available to the Plan and the Plan Administrator or to the Covered Individual who is the subject of the information in accordance with 45 CFR § 164.524.

(f) Employer will make a Covered Individual's Protected Health Information available for amendment, and will on notice amend a Covered Individual's Protected Health Information, in accordance with 45 CFR § 164.526.

(g) Employer will track disclosures it may make of a Covered Individual's Protected Health Information that are accountable under 45 CFR § 164.528 so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 CFR § 164.528, and will make available such information.

(h) Employer will make its internal practices, books, and records relating to its use and disclosure of a Covered Individual's Protected Health Information received from the Plan available to the Plan, the Administrator, and the U.S. Department of Health and Human Services to determine compliance with the HIPAA Privacy Rule at 45 CFR Part 164, Subpart E.

(i) Employer will, if feasible, return or destroy all Protected Health Information of a Covered Individual, in whatever form or medium, recevied from the Plan, including all copies thereof and all data, compilations, or other works derived therefrom that allow identification of any Covered Individual who is the subject of the Protected Health Information, when the Covered Individual's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all such Protected Health Information, Employer will limit the use or disclosure of any Covered Individual's Protected Health Information that cannot feasibly be returned or destroyed to those purposes that make the return or destruction of the information infeasible.

(j) Employer will ensure that the adequate separate between the Plan and the Employer (*i.e.*, the "firewall") required in § 20B-907 and 45 CFR § 504(f)(2)(iii), is satisfied.

§ 20B-906 Other Disclosures to the Employer.

Nothing in this Article shall prohibit or in any way limit the Plan from disclosing a Covered Individual's Protected Health Information to the Employer where HIPAA permits such disclosure in the absence of the requirements of §§ 20B-904 and 20B-905, including, to the extent permitted by HIPAA, the disclosure of Protected Health Information:

(a) that is Summary Health Information, upon the request of the Employer for the purpose of modifying, amending, or terminating this Plan;

(b) on whether an individual is participating in the Plan; or

(c) pursuant to and in accordance with a valid individual authorization under the HIPAA Privacy Rule.

§ 20B-907 Adequate Separation Between the Employer and the Plan.

(a) Employees of the Employer to be Given Access to Information. Only the Borough Manager and the Borough Treasurer may be given access to a Covered Individual's Protected Healh Information received by the Employer from the Plan or a business associate servicing the Plan, except that members of Borough Council may be given access to the information described in § 20B-906(a) or (b).

(b) Purposes of Use. The persons identified in subsection (a) will have access to a Covered Individual's Protected Health Information only to perform the plan administration functions specified in § 20B-904 that Employer provides for the Plan, or in accordance with permitted disclosures made under § 20B-906.

(c) Disciplinary Action. The persons identified in subsection (a) will be subject to disciplinary action and sanctions pursuant to the Employer's employee discipline and termination procedures, for any use or disclosure of a Covered Individual's Protected Health Information in breach of or violation of or noncompliance with the provisions of this Article. Such disciplinary action may include one or more of the following to the extent not inconsistent with other applicable disciplinary policies: written or oral warning or reprimand, required additional training and education, limitations on or revocation of access to Protected Health Information, diminution of duties, suspension, probation, disqualification for bonus or other pay or promotion, demotion in pay or status, referral for criminal prosecution, a requirement to reimburse the Plan or Employer for damages, removal from position, or discharge.

§ 20B-908 Investigation of Incidents of Noncompliance.

If the Employer becomes aware of any issues relating to noncompliance with the requirements of this Article, the Epmolyer shall undertake an investigation to determine the extent, if any, of such noncompliance;

the individuals, policies, practices, or procedures responsible for the noncompliance; and, to the extent feasible, appropriate means for curing or mitigating the effects of noncompliance and preventing such noncompliance in the future.

§ 20B-909 Security Measures for Electronic Protected Health Information.

The Borough Manager will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

§ 20B-910 Notification of Security Incidents.

The Employer will report to the Plan and the Administrator any attempted or successful unauthorized access, use, disclosure, modification, or destruction of information, or interference with system operations in the Employer's information systems, of which the Employer becomes aware.

SECTION 33. Codified Ordinances Chapter 20B, Article X (relating to Health Reimbursement Arrangement for Police Employees—Miscellaneous) is amended by amending §§ 20B-1001, 20B-1002, and 20B-1004 as follows (with deletions indicated by ~~strike outs~~ and insertions indicated by double underlining):

§ 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, or 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-1004 Information to be Furnished.

Participants shall provide the Employer~~,~~ and 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.

* * *

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DULY ORDAINED and **ENACTED** by the Borough Council of the Borough of Alburtis, this 28th 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 28th day of January, 2015, the above Ordinance is hereby APPROVED.

_____
Kathleen Palmer, Mayor