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RETIREE MEDICAL INSURANCE EXPENSE REIMBURSEMENT PLAN

Effective January 1, 2015

MILLVILLE HOUSING AUTHORITY

RETIREE MEDICAL INSURANCE EXPENSE REIMBURSEMENT PLAN

PURPOSE

The Millville Housing Authority Retiree Medical Insurance Expense Reimbursement Plan (the "Plan") is adopted by Millville Housing Authority effective as of January 1, 2015. The purpose of the Plan is to memorialize in writing the continuation of the Millville Housing Authority policy of paying for individual coverage of certain health insurance benefits provided to certain former employees. Millville Housing Authority intends that the Plan qualify as a "plan" under Section 105 of the Internal Revenue Code of 1986 ("Code") as amended, and that the payment of Medical Insurance Premiums that a Participant receives under the Plan be eligible for exclusion from the Employee's income for federal income tax purposes.

Although this Plan has been reduced to writing in order to comply with Section 105 of the Code, the Plan shall also serve as an amendment to Policy 27 of the Millville Housing Authority.

SECTION 1. DEFINITIONS

The words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context, and pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural.

"**Adoption Agreement**" means the written agreement by which an Affiliated Company adopts this Plan.

"**Affiliated Company**" means:

(i) any company which is a member of a controlled group of corporations with the Employer within the meaning of Section 1563(a) of the Code, determined without regard to Sections 1563(a)(4) and (e)(3)(C);

(ii) all organizations under common control with the Employer within the meaning of Section 414(c) of the Code:

(iii) all organizations which are included with the Employer in an affiliated service group within the meaning of Section 414(m) of the Code; or

(iv) any other entity required to be aggregated with the Employer pursuant to regulations under Section 414(o) of the Code.

"**Code**" means the Internal Revenue Code of 1986, as amended.

"**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"**Covered Spouse**" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code), but only if the Participant was hired by the Employer prior to January 1, 2001.

"**Effective Date**" means January 1, 2015.

"**Eligible Employee**" means any Employee who has participated in the Employer health insurance plan of the Employer for at least 15 Years of Service.

"**Employee**" mean any person who is engaged in the conduct of the business of a Participating Employer, excluding independent contractors and individuals of a collective bargaining unit.

"**Employer**" means Millville Housing Authority and any Affiliated Company which signs an Adoption Agreement to become a Participating Employer.

"**Entry Date**" means the date on which the Eligible Employee has a Separation from Service and is no longer eligible to participate in the Employer Health Insurance Plan.

"**ERISA**" means the Employee Retirement Income Security Act of 1974, and the same as may be amended from time to time.

"**HIPAA**" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"**Health Insurance Plan(s)**" means the group medical insurance plan(s) available to Employees from time to time from the Employer for its full-time employees.

"**Participant**" means any Eligible Employee who has met the conditions for participation set forth in Section 2.

"**Participation Agreement**" means the form required by the Employee acknowledging participation in the Retiree Medical Insurance Reimbursement Plan.

"**Participating Employer**" means Millville Housing Authority and any Affiliated Company that adopts this Plan with the consent of the Employer.

"**Period of Coverage**" means the period of time from the Entry Date until either the end of the coverage period set forth in Section 2.3(a), or a cessation of participation under Section 2.4, if earlier.

"**Plan**" means the Millville Housing Authority Retiree Medical Insurance Expense Reimbursement Plan which is described herein, as amended from time to time, and which is intended to constitute a separate, written Plan for the exclusive benefit of Eligible Employees.

"**Plan Administrator**" shall mean the Employer or any person or firm appointed by the Employer to administer the Plan.

"**Plan Number**" or "PN" is _____.

"**Plan Sponsor**" means Millville Housing Authority.

"**Separation from Service**" means the Employee's termination of eligibility to participate in the Employer's Health Insurance Plan(s).

"**Year of Service**" means the completion of 12 months of employment subsequent to the initial date of participation in the Employer's Health Insurance Plan(s).

SECTION 2. PARTICIPATION IN THE PLAN

2.1 **Eligibility to Participate**. Each Eligible Employee may elect to participate in the Plan if the Individual satisfies the following: (a) was an Employee of the Employer and participated in the Employer's Health Insurance Plan(s) for at least fifteen (15) years; or (b) is the Covered Spouse of an Employee who satisfies subsection (a) hereof.

2.2 **Procedure for and Effect of Participation.**

An Eligible Employee and Covered Spouse:

(a) will become a Participant in the Plan, upon completing a Participation Agreement. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of this Plan and all amendments thereto. All

current Eligible Employees participating in one or more of the Employer's Medical Insurance Plans are automatically in this Plan.

(b) The Participation Agreement will require the Eligible Employee to certify that: (1) he/she satisfies the eligibility requirement of Section 2.1, above, (2) has incurred health insurance premiums eligible for reimbursement under Section 2.3, below, and (3) has not incurred a cessation of participation under Section 2.4, below.

2.3 **Reimbursement Benefits.**

(a) Period of Coverage. Upon an Eligible Employee's Separation from Service, the Eligible Employee and Covered Spouse will become a Participant in this Plan upon completion of the Participation Agreement and documentation of health insurance costs for the following periods:

Years of Service upon a Separation from Service	Maximum Length of Coverage
25 years or more	5 years
15 years or more	2 years

(b) Amount of Coverage Prior to Medicare Eligibility.

(i) Upon a Separation from Service, for a period of 18 months or until the Eligible Employee or Covered Spouse becomes eligible for Medicare, whichever is shorter, the Employer will reimburse (or pay directly to the insurance carrier) the cost of COBRA coverage, Level 1 and Level 2 deductibles, and

(ii) Subsequent to 18 months after a Separation from Service or the date on which the Eligible Employee becomes eligible for Medicare, whichever is shorter, the Employer will reimburse the Eligible Employee (or pay directly to the insurance carrier) up to $800 per person per month toward the cost of health insurance purchases by the Eligible employee;

(iii) Coverage under (i) and (ii) will also be provided for a Covered Spouse, if the Covered Spouse was a participant in the Employer's Health Insurance Plan(s) on the date of an Eligible Employee's Separation from Service).

(c) Amount of Coverage After Medicare Eligibility. On the date an Eligible Employee becomes eligible for Medicare, the reimbursement to the Participant and Covered Spouse shall: (1) reduce to $350 per month, and (2) will be provided only to reimburse the costs of health insurance coverage purchased through the marketplace that is secondary to Medicare Part A.

2.4 **Cessation of Participation**. A Participant and Covered Spouse will cease to be a Participant as of the earliest of:

(a) the date on which the Plan terminates;

(b) the date on which an Eligible Employee obtains employment that offers health insurance coverage comparable to the Health Insurance Plan(s);

(c) the date on which the Eligible Employee ceases to pay premiums for health insurance;

(d) as to the Covered Spouse, the date on which a Covered Spouse become eligible for Medicare; or

(e) the date on which an Eligible Employee is rehired by the Employer and becomes eligible to participate in the Employer's Health Insurance Plan(s).

2.5 **Non-FMLA Leaves of Absence**. An Eligible Employee who goes on an unpaid leave of absence that does not affect eligibility to participate in the Health Insurance Plan(s) shall not incur a Separation from Service until the Eligible Employee becomes eligible for COBRA benefits.

2.6 **Uniformed Service Under USERRA**. An Eligible Employee who is absent from employment with the Employer on account of being in "uniformed service", as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), shall not be eligible to participate in the Plan until the lesser of 18 months or until the Eligible Employee fails to apply for reinstatement or to return to employment with the Employer.

SECTION 3. PLAN ADMINISTRATOR

3.1 **Plan Administrator**. The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them. Millville Housing Authority shall act as Plan Administrator.

3.2 **Powers of the Plan Administrator**. The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan;

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

3.3 **Reliance on Participant, Tables, etc**. The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

3.4 **Provision for Third-Party Plan Service Providers**. The Plan Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement with a third party, obligations under this Plan shall remain the obligation of the Employer.

3.5 **Fiduciary Liability**. To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

3.6 **Compensation of Plan Administrator**. Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

3.7 **Effect of Mistake**. In the event of a mistake as to the eligibility or participation of an Eligible Employee or Covered Spouse or as to the amount of benefits paid or to be paid to an Eligible Employee or Covered Spouse, the Plan Administrator shall, to the extent that it deems administratively possible, cause to be accelerated, or otherwise make adjustment of such amounts as will in its judgment accord to such Eligible Employee or Covered Spouse the benefits provided herein.

SECTION 4. CLAIMS AND CLAIMS REVIEW PROCEDURE

In the event a dispute arises over benefits under this Agreement and benefits are not paid to Eligible Employee or Participant, and such claimant feels he is entitled to receive such

benefits, then a written claim must be made to the Plan Administrator within 60 days from the date eligibility or payments are refused. The Plan Administrator shall review the written claim and, if the claim is denied, in whole or in part, the Plan Administrator shall provide in writing within 90 days of receipt of such claim (i) its specific reasons for such denial, (ii) reference to the specific provisions of this Agreement upon which the denial is based, (iii) a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary, and (iv) a description of the Agreement's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

If a claimant desires a second review, the claimant shall notify the Employer in writing within 60 days of the claimant's receipt of the first claim denial. The claimant may review this Agreement or any documents relating thereto and submit any written issues and comments, documents, records and other information relating to the claim that the claimant feels may be appropriate. The claimant shall be provided - upon request and free of charge - reasonable access to, and copies of, all documents, records and other information relating to the claim for benefits. The claimant may submit comments, documents, records and other information relating to the claim and the Employer's Board of Commissioners or its designee shall take into account all such information submitted without regard to whether such information was submitted or considered in the initial benefit determination. In the sole discretion of the Board of Commissioners or its designee, it shall then review the second claim and provide a written decision within 60 days of receipt of such claim. This decision shall likewise state the specific reasons for the decision and shall include reference to specific provisions of this Agreement upon

which the decision is based. The decision on review shall also include (i) a statement that the claimant is entitled to receive - upon request and free of charge - reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits, and (ii) a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

SECTION 5. MISCELLANEOUS

5.1 **Amendment and Termination**. The Employer may amend or terminate this Plan at any time. No amendment shall deprive any Participant or Covered Spouse of any benefit to which he or she is entitled under this Plan and which is in pay status.

5.2 **Effect of Plan on Employment**. The Plan shall not be deemed to constitute a contract of employment between the Participating Employer and any Participant or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Participating Employer or to interfere with the right of the Participating Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him or her as a Participant of this Plan.

5.3 **Alienation of Benefits**. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated.

5.4 **Facility of Payment**. If the Employer deems any person incapable of receiving benefits to which he is entitled by reason of not having reached the age of majority, illness, infirmity, or other incapacity, it may direct that payment be made directly for the benefit of such

person or to any person selected by a Participating Employer to disburse it, whose receipt shall be a complete aquittance therefore. Such payments shall, to the extent thereof, discharge all liability of the Participating Employer.

5.5 **Proof of Claim**. As a condition of receiving benefits under the Plan, any person may be required to submit whatever proof the Plan Administrator may require either directly to the Plan Administrator or to any person delegated by him/her.

5.6 **Status of Benefits**. The Employer believes that this Plan is in compliance with section 105 of the Code and that it provides certain benefits to Employees which are tax free pursuant to other provisions of the Code. This Plan has not been submitted to the Internal Revenue Service for approval and thus there can be and is no assurance that intended tax benefits will be available. Any Participant, by accepting benefits under this Plan, agrees to be liable for any tax that may be imposed with respect to those benefits, plus any interest as may be imposed.

5.7 **Applicable Law**. The Plan shall be construed and enforced according to the laws of the State of New Jersey to the extent not preempted by any federal law.

5.8 **Funding this Plan**. All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust of other fund from which Premiums are paid.

5.9 **Severability**. If any provision of this Plan shall be held invalid or unenforceable, such invalidity or unenforceability shall not affect any other provision, and this Plan shall be construed and enforced as if such provision had not been included.

5.10 **Heirs and Assigns**. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and Beneficiary.

5.11 **Headings and Captions**. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

5.12 **Information to be Furnished**. Participants shall provide the Employer and/or Participating Employer with such information and shall complete and sign such forms and documents, as may reasonably be requested from time to time for the purpose of administration of the Plan.

Executed _____, 2015

Effective January 1, 2015

MILLVILLE HOUSING AUTHORITY

_____ By:_____

Witness

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