BOROUGH OF ALBURTIS
LEHIGH COUNTY, PENNSYLVANIA

Ordinance No. 454

(Duly Adopted January 10, 2007)

AN ORDINANCE PROVIDING A MEANS FOR QUALIFIED EMPLOYEES TO BE ABLE TO ELECT TO PAY FOR CERTAIN MEDICAL EXPENSES THROUGH PRE-TAX DOLLARS RATHER THAN AFTER-TAX DOLLARS, BY: ADDING A NEW CHAPTER 14 TO THE ALBURTIS CODIFIED ORDINANCES TO ESTABLISH A CAFETERIA PLAN FOR ELIGIBLE EMPLOYEES (INCLUDING PROVISIONS RELATING TO TITLE, ESTABLISHMENT, AND GENERAL DEFINITIONS; PARTICIPATION; ELECTION OF OPTIONAL BENEFITS; ADMINISTRATION; AMENDMENT & TERMINATION; AND MISCELLANEOUS); ADDING A NEW CHAPTER 20 TO THE ALBURTIS CODIFIED ORDINANCES TO ESTABLISH A MEDICAL EXPENSE REIMBURSEMENT PLAN FOR ELIGIBLE EMPLOYEES (INCLUDING PROVISIONS RELATING TO TITLE, ESTABLISHMENT, AND GENERAL DEFINITIONS; PARTICIPATION & LEVEL OF COVERAGE; MEDICAL EXPENSE REIMBURSEMENT ACCOUNTS; BENEFITS; CLAIMS PROCEDURE; ADMINISTRATION; AMENDMENT & TERMINATION; TAX IMPLICATIONS; AND MISCELLANEOUS); AND AMENDING CHAPTER 12 OF THE ALBURTIS CODIFIED ORDINANCES (RELATING TO PERSONNEL POLICIES) TO REFERENCE THE MEDICAL EXPENSE REIMBURSEMENT PLAN.

WHEREAS, the Borough Council of the Borough of Alburtis desires to adopt a Cafeteria Plan and a Medical Expense Reimbursement Plan to provide a means for qualified employees of the Borough to be able to elect to pay for certain medical expenses through pre-tax dollars rather than after-tax dollars;

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

SECTION 1. The Codified Ordinances are hereby amended by adding the following new Chapter 14:

Chapter 14 — Cafeteria Plan

Article I — Title, Establishment, and General Definitions

§ 14-101 Short Title.

This Chapter shall be known, and may be cited, as the "Borough of Alburtis Cafeteria Plan."

§ 14-102 Establishment.

The Borough of Alburtis hereby establishes a Cafeteria Plan in order to provide certain employees with a choice between cash compensation and coverages under the health and medical expense reimbursement plans maintained by the Borough of Alburtis. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as it may be amended from time to time.

§ 14-103 Definitions—In General.

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

§ 14-104 Administrator.

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

§ 14-105 Code.

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

or any corresponding provision of any future legislation that amends, supplements or supersedes that section.

§ 14-106 Effective Date.

The "Effective Date" of this Plan is February 1, 2007.

§ 14-107 Eligibility Month.

The term "Eligibility Month" means the month following the month in which an employee of the Employer first completes thirty (30) days of service with the Employer as a Qualified Employee, including intervening weekends, holidays, other nonscheduled days, and permitted leave as days of service. A person who was a Qualified Employee, then ceased to be a Qualified Employee, and who again becomes a Qualified Employee, and who is treated as a new employee under the provisions of this Plan shall have a new Eligibility Month for the new period of service as a Qualified Employee.

§ 14-108 Employer.

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

§ 14-109 Health Plan.

The term "Health Plan" shall mean the health/medical/hospitalization coverage plan provided from time to time under § 12-403 (relating to Personnel Policies—Benefits—Health & Hospitalization). As of the Effective Date, the Health Plan is the Capital Blue Cross PPO 250 Plan with the Option One Card Plan for prescription drug coverage as provided for the Borough of Alburtis under applicable documents with Capital Blue Cross and its affiliates, but the specific plan and/or the coverages available under the plan may change from time to time.

§ 14-110 Key Employee.

The term "Key Employee" shall mean, for any Plan Year, any person who at any time during the Plan Year is a key employee, as defined in Code § 416(i)(1) and the regulations thereunder, with respect to the Employer. In general, and subject to the more specific definition provided in the Code and the regulations, the term "Key Employee" means certain officers having an annual compensation greater than $130,000 (or such higher amount as shall be established by the Internal Revenue Service to adjust for changes in the cost of living) and certain persons having an ownership interest in any Employer. However, the term "Key Employee" does not include any officer or employee of an entity referred to in Code § 414(d) (relating to definition of governmental plan), including the Borough of Alburtis.

§ 14-111 Medical Expense Reimbursement Plan.

The term "Medical Expense Reimbursement Plan" shall mean the Borough of Alburtis Medical Expense Reimbursement Plan under Chapter 20, as amended from time to time.

§ 14-112 Participant.

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

§ 14-113 Plan.

The term "Plan" shall mean the **Borough of Alburtis Cafeteria Plan**, as set forth in this Chapter, and as it may be amended from time to time.

§ 14-114 Plan Year.

The term "Plan Year" shall mean any 12 consecutive month period beginning on January 1 and ending on the following December 31. However, the first Plan Year under this Plan shall be the period from February 1, 2007 through December 31, 2007, inclusive.

§ 14-115 Qualified Employee.

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

(a) a nonresident alien who receives no remuneration from the Employer which constitutes income from sources within the United States (within the meaning of the Code); nor

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

§ 14-116 Related Employer.

The term "Related Employer" shall mean any—

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

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

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

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

§ 14-117 Sponsor.

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

Article II — Participation

§ 14-201 Commencement of Participation.

Every Qualified Employee who is employed by the Employer on February 1, 2007 shall become a Participant in the Plan on the Effective Date, February 1, 2007. All other Qualified Employees shall become a Participant in the Plan on the first day of their Eligibility Month.

§ 14-202 Cessation of Participation.

A Participant will cease to be a Participant as of the *earlier* of—

(a) the date on which the Plan terminates; or

(b) the date on which he ceases to be a Qualified Employee.

§ 14-203 Reinstatement of Former Participant.

A former Participant will become a Participant again as follows:

(a) If the former Participant becomes a Qualified Employee again during the same Plan Year in which he ceased to be a Participant, he will become a Participant again on the date he becomes a Qualified Employee again (without any waiting period);

(b) If the former Participant becomes a Qualified Employee again during a Plan Year after the Plan Year in which he ceased to be a Participant, he will be treated in the same way as a new employee, his Eligibility Month will be calculated based on the date he became a Qualified Em-

ployee again, and he will become a Participant again under the rules of § 14-201.

Article III — Election of Optional Benefits

§ 14-301 Coverage Options.

Each Participant may choose under this Plan to receive his/her full compensation for any Plan Year in cash or to have a portion of it applied by the Employer towards the cost of coverage available to the Participant under one or more of the following plans, to the extent not otherwise paid for or provided by the Employer:

(a) The Health Plan. If the Health Plan is selected, *one* of the coverage options available under the Health Plan must be selected as well. The options available as of the Effective Date are:

(1) Single (coverage for the Participant only);

(2) Husband/Wife (coverage for the Participant and his/her spouse);

(3) Employee/Child (coverage for the Participant and one of his/her eligible children);

(4) Family (coverage for the Participant, his/her spouse, and his/her eligible children).

(b) The Medical Expense Reimbursement Plan.

§ 14-302 Descriptions of Optional Benefits Provided in Underlying Plans.

While the election of one or more of the optional coverages described in § 14-301 may be made under this Plan, the coverages and benefits thereunder will be provided not by this Plan but by the particular plan(s) selected. The types and amounts of benefits available under each options described in § 14-301, the requirements for participating in such

option, and the other terms and conditions of coverage and benefits under such option are as set forth from time to time in the Health Plan, the Medical Expense Reimbursement Plan, and in any insurance or other contracts that constitute or are incorporated by reference in certain of those plans. The benefit descriptions in such plans and contracts, as in effect from time to time, are hereby incorporated by reference into this Plan.

§ 14-303 Election of Optional Coverages in Lieu of Cash.

A Participant may elect under this Plan to receive one or more of the optional coverages described in § 14-301, to the extent available to the Participant under the applicable plans, in accordance with the following procedures:

(a) Health Plan.

(1) In General. If a Participant elects coverage for a Plan Year under the Health Plan, the Participant's regular cash compensation for the Plan Year will be reduced in an amount equal to the sum of the amounts which the Participant is required to contribute for Health Plan coverage with respect to the paydays during the Plan Year. The amount of the required employee contribution for any given payday is determined under § 12-403(c)(2), (3) (relating to Personal Policies—Benefits—Health & Hospitalization—Employee Contributions to Premiums). The balance of the cost of such coverage shall be paid by the Employer with nonelective Employer contributions.

(2) Compensation Reductions Per Payday. The amount of compensation to reduced from any given paycheck for the Health Plan shall be shall be equal to the amount which the Participant must contribute for that payday under § 12-403(c)(2), (3) (relating to Personal Policies—Benefits—Health & Hospitalization—Employee Contributions to Premiums).

(b) Medical Expense Reimbursement Plan.

(1) In General. If a Participant elects coverage for a Plan Year under the Medical Expense Reimbursement Plan, the Participant's regular cash compensation for the Plan Year will be reduced by the dollar

amount of the coverage which the Participant elects, up to the maximum amount of coverage available to the Participant under that plan.

(2) Compensation Reductions Per Payday.

(A) Except as provided in subparagraphs (B) through (D), the amount to be reduced from each regular paycheck in the Plan Year to provide coverage under the Medical Expense Reimbursement Plan shall be equal to the total amount of reductions to be made for the Plan Year divided by the number of regular paychecks that a person would receive in that Plan Year if he worked for the entire Plan Year. When coverage is selected for a Plan Year, the amount of the coverage will be credited to a reimbursement account for the Participant for the Plan Year under and in accordance with the terms of the Medical Expense Reimbursement Plan. No further credits will be made to the reimbursement account when reductions are made from any paychecks.

(B) Notwithstanding subparagraph (A), if the amount to be reduced from any paycheck to provide coverage under the Medical Expense Reimbursement Plan is *greater* than the amount earned during the pay period covered by the paycheck (after taxes, any reductions to provide coverage under the Health Plan, and other deductions other than the reduction to be made to provide coverage under the Medical Expense Reimbursement Plan), the excess shall be added to the amount to be reduced from the following regular paycheck (unless such coverage under the Medical Expense Reimbursement Plan is terminated or is paid for by the Participant outside of this Plan).

(C) If a person becomes a Participant after the beginning of a Plan Year, the only paychecks which shall be counted in determining the total number of paychecks which may be received during a Plan Year shall be those regular paychecks for pay periods beginning on or after the date the person becomes a Participant.

(D) If a Participant files a new election for the Medical Expense Reimbursement Plan effective after the beginning of a Plan Year under the provisions of § 14-305, the amount to be reduced from each regular paycheck during the Plan Year after the effective date of the new election shall be equal to:

(I) the amount of coverage elected in the new election *minus* the amount of contributions to the Medical Expense Reimbursement Plan made prior to the effective date of the new election; *divided by*

(II) the number of regular paychecks remaining in the Plan Year from and after the effective date of the new election.

When coverage is changed for a Plan Year, the amount of any increase in the coverage will be credited to the reimbursement account for the Participant for the Plan Year, and the amount of any decrease in coverage will be debited from the reimbursement account for the Participant for the Plan Year, in accordance with the terms of the Medical Expense Reimbursement Plan.

§ 14-304 Election Procedure.

(a) In General. Approximately 30 days prior to the commencement of each Plan Year, the Administrator shall provide one or more written election forms and compensation reduction agreements to each Participant and to each other individual who is expected to become a Participant at the beginning of the Plan Year. The election forms shall be effective as of the first day of the Plan Year. Each Participant who desires one or more optional benefit coverages described in § 14-301 for the Plan Year shall so specify on the appropriate election form(s) and shall agree to a reduction in his/her compensation as provided in § 14-303. Each election form must be completed and returned to the Administrator on or before such date as the Administrator shall specify, which date shall be no later than the beginning of the Plan Year.

(b) New Participants. Before an individual becomes a Participant under § 14-201 or § 14-203(b), the Administrator shall provide written election forms and compensation reduction agreements described in subsection (a) to the individual. Each Participant who desires one or more optional benefit coverages described in § 14-301 for the balance of the Plan Year (beginning on the first date permitted under the benefit plan(s) elected) shall so specify on the appropriate election form(s) and shall agree to a reduction in his/her compensation as provided in § 14-303.

Each election form must be completed and returned to the Administrator on or before the date the person becomes a Participant. The election forms shall be effective as of the date the person becomes a Participant.

(c) Failure to Return Election Forms.

(1) In General. Except as provided in paragraph (2), a Participant's failure to return a completed election form under this § 14-304 to the Administrator on or before the specified due date shall constitute an election to receive his/her full compensation in cash.

(2) Health Plan Coverage. A Participant's failure to return a completed election form to the Administrator relating to coverage under the Health Plan on or before the due date for any Plan Year after the first Plan Year of this Cafeteria Plan shall constitute—

(A) a re-election of the same coverage or coverages, if any, as was in effect just prior to the end of the preceding Plan Year (to the extent such coverage(s) remain available under the Health Plan and this Cafeteria Plan), and

(B) an agreement to a reduction in the Participant's compensation for the Plan Year in the amount determined under § 14-303.

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

(a) In General. Any election made under the Plan (including an election through inaction under § 14-304(c)) for a given Plan Year shall be *irrevocable* by the Participant during the Plan Year, except as otherwise provided in this § 14-305.

(b) Change in Status.

(1) In General. A Participant may revoke an election in writing for the balance of the Plan Year, and, if desired, file a new election in writing if, under the facts and circumstances—

(A) a "change in status" occurs within the meaning of paragraph (2);

(B) the requested revocation and new election are "consistent" with the change in status, in accordance with the rules of paragraph (3);

(C) the change is consistent with the terms of the plan(s) in question; *and*

(D) any new coverage amount elected under the Medical Expense Reimbursement Plan is *either* higher than the former coverage amount *or* is not less than the amount of Qualifying Medical Care Expenses (as defined in § 20-118) incurred by the Participant for the Plan Year through the effective date of the new election. (The new coverage amount selected shall reflect a total amount of coverage for the entire Plan Year, including both benefits paid through the effective date of the new election and the amount of additional reimbursements potentially available for the Plan Year.) If the Participant submits reimbursement claims which demonstrate that the revocation and new election are in violation of the provisions of this paragraph (2), the Plan Administrator shall automatically increase the Participant's coverage amount for the Plan Year to the amount which would have satisfied this paragraph (2), and shall adjust the amount withheld from each paycheck after the date of the adjustment under the provisions of § 14-303(b)(2)(D) as if there had been a new coverage election filed on the date of the adjustment.

(2) Change in Status. For purposes of paragraph (1), a change in status includes the following events:

(A) Legal Marital Status. An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment.

(B) Number of Dependents. An event that changes a Participant's number of dependents, including birth, death, adoption, or placement for adoption.

(C) Employment Status. An event that changes the employment status of the Participant or the Participant's spouse or dependen, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's

employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of his/her employer.

(D) Requirements for Dependents. An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(E) Residence. A change in the place of residence of the Participant, his/her spouse or dependent.

(F) Other. Such other events as the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

(3) Consistency Requirements. A Participant's requested revocation and new election under this subsection (b) will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a plan of the Employer or under a plan maintained by the employer of the Participant's spouse or dependent. A change in status that affects the eligibility under an employer's plan shall include a change in status that results in an increase or decrease in the number of a Participant's family members or dependents who may benefit from coverage under the plan. For further rules regarding the application of this consistency requirement, *see* Treas. Regs. § 1.125-4(c)(3), which is incorporated herein by reference.

(c) Special Enrollment Rights. Since none of the plans under this Plan are subject to Code § 9801(f) (relating to HIPAA special enrollment rights), since those provisions do not apply to a governmental plan (Code § 9831(a)), and also since the benefits under the Medical Expense Reimbursement Plan are "excepted benefits," a Participant may not revoke an election and file a new election under Treas. Regs. § 1.125-4(b) with respect to special enrollment rights.

(d) Certain Domestic Relations Orders. In the case of a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child

support order) that requires accident or health coverage for a Participant's child or for a foster child who is a dependent of the Participant, a Participant may change his/her election—

(1) in order to provide coverage for the child under the Health Plan if the order so requires; or

(2) in order to cancel coverage under the Health Plan for the Participant's child if such order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) Medicare or Medicaid Entitlement. In the case of coverage under the Health Plan, a Participant may revoke an election for the balance of the Plan Year and file a new election in order to cancel or reduce such coverage for the Participant or any covered dependent of the Participant to the extent that the Participant or dependent becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election for the balance of the Plan Year to commence or increase coverage under the Health Plan.

(f) Change in Costs of Health Plan Coverage. In the case of coverage under the Health Plan, if—

(1) the Participants' share of the cost of such coverage significantly increases during the Plan Year, Participants electing such coverage for the Plan Year may revoke their election and either elect a similar coverage under another group health plan of the Employer included within this Cafeteria Plan for the balance of the Plan Year (other than the Medical Expense Reimbursement Plan) or drop such coverage if there is no similar coverage available;

(2) if the Participants' share of the cost of such coverage significantly decreases, Participants may elect to commence participation in

the Health Plan, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

(g) Significant Curtailment of Health Plan Coverage. In the case of coverage under the Health Plan, if the Participant or his/her spouse or dependent experiences a significant curtailment in coverage during the Plan Year, the Participant may make a corresponding change in election under the Plan for the balance of the Plan Year as follows:

(1) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his/her election and elect a similar coverage under another group health plan of the Employer including within this Cafeteria Plan (other than the Medical Expense Reimbursement Plan), but only if any such similar coverage exists;

(2) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his/her election and either elect a similar coverage under another group health plan of the Employer included within this Cafeteria Plan (other than the Medical Expense Reimbursement Plan) for the balance of the Plan Year, or drop such coverage if there is no similar coverage available.

(h) New or Improved Benefits Available. If, during the Plan Year, a new benefit option becomes available under this Plan or an existing benefit option is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year, *provided* that no such election change may be made as to the Medical Expense Reimbursement Plan.

(i) Elections by Spouse or Dependent Under Plan of Their Employer. In the event that a Participant's spouse or dependent makes an election change under a plan maintained by his/her employer, the Administrator may permit the Participant to revoke an election under this Plan and make a new election for the balance of the Plan Year that is on account of and corresponds with the election change made by the Participant's spouse or dependent, if—

(1) the election change made by the Participant's spouse or dependent under his/her employer's plan satisfies the regulations and rulings under Code § 125; *or*

(2) the period of coverage under the plan maintained by the Participant's spouse or dependent does not correspond with the Plan Year of this Plan.

(j) Loss of Group Health Coverage Sponsored by Governmental or Educational Institution. In the event that a Participant or his/her spouse or dependent loses group health coverage sponsored by a governmental or educational institution (*see* Treas. Regs. § 1.125-4(f)(5)), the Participant may elect coverage under the Health Plan and/or the Medical Expense Reimbursement Plan for the balance of the Plan Year for the Participant, his/her spouse or dependents.

(k) Time for Change. Unless otherwise required by law, any application for a revocation and new election under this § 14-305 must be made within the time specified by the Administrator following the date of the actual event.

(l) Effective Date of Change. Unless otherwise required by law, any revocation and new election under this § 14-305 shall be effective—

(1) on the first day of the month following the month the new election is filed, with respect to coverage under the Health Plan;

(2) on the first day of the first pay period which beings after the new election is filed, with respect to coverage under the Medical Expense Reimbursement Plan.

(m) Dependent. For purposes of this § 14-305, the term "dependent" has the same meaning as under Code § 152, except that any child to whom Code § 152(e) applies is treated as a dependent of both parents.

§ 14-306 Changes by Administrator to Avoid a Violation of Nondiscrimination Requirements or Benefit Limitations for Key Employees or Other Special Classes of Employees.

(a) In General. If the Administrator determines, before or during any Plan Year, that this Plan, the Health Plan, and/or the Medical Expense

Reimbursements Plan may fail to satisfy for such Plan Year any nondiscrimination requirement imposed by the Code or any limitation on benefits for Key Employees or other categories of employees established by the Code, the Administrator shall take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirement or limitation (including a margin of safety). Such action may include, without limitation, a modification of elections by highly compensated employees, Key Employees, or other classes of employees, as defined by the Code for purposes of the nondiscrimination requirement or benefit limitation in question, *without* the consent of such employees, or directions to the plan administrator of the Medical Expense Reimbursement Plan to limit or delay benefit payments to such employees.

(b) Limitation on Benefits to Key Employees. The Administrator shall use its best efforts to insure that the total statutory nontaxable benefits provided in any Plan Year to Key Employees in benefit plans provided under this Cafeteria Plan does not exceed twenty-five percent (25%) of the aggregate of such benefits provided for all employees under this Plan for such Plan Year, as required under Code § 125(b)(2) to preserve favorable tax treatment of contributions by and benefits to Key Employees.

(c) Modifications and Benefit Limitations.

(1) Modifications of elections and instructions to limit or delay benefits under subsection (a) which are based on the benefit limitations for Key Employees described in subsection (b)—

(A) shall be made to the greatest extent possible under the Medical Expense Reimbursement Plan before any modifications are made for any Participant under the Health Plan; and

(B) as between Participants, reductions shall be made by imposing an overall limitation on the total coverage amounts for the Plan Year under the Medical Expense Reimbursement Plan, and applying that limitation to all Participants in the affected class who elected coverage in an amount greater than the limitation.

(2) Modifications of elections and instructions to limit or delay benefits under subsection (a) which are based on nondiscrimination requirements or benefit limitations applicable to the Medical Expense Reimbursement Plan *individually* and not to this Cafeteria Plan as a whole, shall be made by imposing an overall limitation on the total coverage amounts for the Plan Year under the Medical Expense Reimbursement Plan, and applying that limitation to all Participants in the affected class who elected coverage in an amount greater than the limitation.

§ 14-307 Adjustment of Compensation Reductions.

If the cost to a Participant of coverage provided by the Health Plan increases or decreases during a Plan Year, then a corresponding change shall be made *automatically* in the compensation reduction of the Participant in an amount reflecting such increase or decrease.

§ 14-308 Automatic Termination and Reinstatement of Election.

Any election made under this Plan (including an election made through inaction under § 14-304(c)) shall automatically terminate on the payday for the pay period in which the Participant ceases to be a Participant in this Plan (or, if the payday occurs after the end of the Plan Year, on the last day of the Plan Year), although coverage or benefits under any underlying plan may continue if and to the extent provided by such plan. In the event such a former Participant shall again become a Participant before the end of the same Plan Year, the elections previously in effect for the Participant shall automatically be reinstated for the balance of the Plan Year except as the Participant may elect otherwise under § 14-305, *subject to the following conditions and modifications*:

(a) Health Plan. The elections for coverage under the Health Plan, and the corresponding paycheck reductions, shall be effective as of the first day of the first month following the month in which the person becomes a Participant again.

(b) Medical Expense Reimbursement Plan. The elections for coverage under the Medical Expense Reimbursement Plan, and the corre-

sponding paycheck reductions, shall be effective as of the day the person becomes a Participant again. Contributions/paycheck reductions will continue thereafter in the same amount *per paycheck* as would have been made per paycheck under § 14-303(b) if there had been no interruption of participation. The coverage amount shall *not* be reduced, even if the Participant did not elect to continue coverage as a participant in the Medical Expense Reimbursement Plan after he ceased to be a Participant in this Plan (or did not have the right to make such an election), *but* no reimbursements shall be made under the Medical Expense Reimbursement Plan for services rendered during the period during the Plan Year for which the Participant was not a participant in the Medical Expense Reimbursement Plan.

§ 14-309 Cessation of Coverage or Benefits Upon Failure to Make Required Payments.

Nothing in this Plan shall prevent the cessation of coverage or benefits under any benefit plan elected under this Cafeteria Plan, in accordance with the terms of such benefit plan, on account of a Participant's failure to pay the Participant's share of the cost of such coverage or benefits, through compensation reduction, after-tax payroll deduction, or otherwise.

§ 14-310 Maximum Elective Contributions.

The maximum amount of elective contributions under the Plan for any Participant for any Plan Year shall be the maximum amount of reimbursements which the Participant may select for the Plan Year under the Medical Expense Reimbursement Plan, *plus* the Participant's share of the cost of the most expensive coverage(s) available to the Participant under the Health Plan for the Plan Year.

§ 14-311 Coordination with Family and Medical Leave Act.

The Employer currently has no "eligible employees" within the meaning of the Family and Medical Leave Act of 1993 because there are fewer than fifty employees, and so no employee has a right to FMLA

leave. *See* 29 U.S.C. § 2611(2)(B)(ii). To the extent that the Family and Medical Leave Act of 1993 applies to the Employer in the future, then notwithstanding anything to the contrary in this Chapter, if the Administrator deems it necessary to or appropriate to assure the Plan's compliance with that Act and any regulations pertaining thereto, the Administrator may—

(a) permit a Participant to revoke (and subsequently reinstate) his/her election of one or more benefit options under this Plan;

(b) adjust a Participant's compensation reduction as a result of such a revocation or reinstatement; and

(c) permit payment of the Participant's share of the cost of a benefit coverage under the Health Plan and/or Medical Expense Reimbursement Plan during an unpaid leave to be made with after-tax dollars.

Article IV — Administration

§ 14-401 In General.

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

§ 14-402 Powers and Duties.

(a) In General. The Administrator shall administer the Plan in accordance with its terms, and shall have all powers necessary to carry out the provisions of the Plan. The Administrator shall have absolute and exclusive discretion to decide all issues arising in the administration, interpretation, and application of the Plan. The Administrator may from time to time set forth rules of interpretation and administration, subject to modification as appropriate in the light of experience. Decisions and rules established by the Administrator shall be conclusive and binding on all persons. The Administrator shall act without discrimination among persons similarly situated at any given time, although it may change its poli-

cies from time to time, and shall always act in the exclusive interest of Plan Participants and their beneficiaries. However, notwithstanding the foregoing, any claim which arises under the Health Plan or the Medical Expense Reimbursement Plan shall not be subject to review under this Plan, and the Administrator's authority under this Article IV shall not extend to any matter as to which an administrator under any such other plan is empowered to make determinations under such plan.

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

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

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

(e) Reports, Documents, and Communications. The Administrator shall prepare and file all reports and documents required to be filed with a governmental agency, shall prepare and provide or make available all reports and documents required to be provided or made available to Participants or persons with an interest under the Plan, and shall commu-

nicate with employees and other persons with respect to all matters relating to the Plan, including rights and benefits under this Plan.

§ 14-403 Indemnification.

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

§ 14-404 Benefits Solely From General Assets.

Except as may otherwise be required by law—

(a) any amount by which a Participant's compensation is reduced under this Plan will remain part of the general assets of the Employer;

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

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

Article V — Amendment and Termination

§ 14-501 Right to Amend or Terminate.

Although the Employer expects to continue this Plan indefinitely, the Employer reserves the right to amend or terminate this Plan at any time by ordinance of the Sponsor.

§ 14-502 Salary Reduction Amounts Not Yet Contributed.

If this Plan is terminated, any salary reductions which have been made by the Employer and which have not yet been contributed to the Medical Expense Reimbursement Plan, and/or used to provide coverage under the Health Plan, as the case may be, shall be contributed and/or used for such purposes. From and after the date of termination, no further salary reductions shall be made from the pay of employees who signed salary reduction agreements.

Article VI — Tax Implications

§ 14-601 No Guarantee of Tax Consequences.

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

§ 14-602 Indemnification of Employer by Participants.

If any Participant makes contributions under this Plan that are not excludable from federal, state, or local income or Social Security taxes, and such taxes were not withheld with respect to such contributions, the Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold such taxes.

Article VII — Miscellaneous

§ 14-701 Acquittance.

This Plan is purely voluntary on the part of the Employer. Except as provided in this Plan document, neither the establishment of the Plan, any modification thereof, nor the payment of any benefits under the Health Plan or the Medical Expense Reimbursement 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.

§ 14-702 Limitation of Liability.

Each person who becomes a Participant under this Plan expressly agrees and understands that neither the Employer, the Administrator, 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.

§ 14-703 Employment Rights.

Nothing contained in this Plan shall be construed or interpreted as giving any employee of the Employer the right to be retained in the serv-

ice of any Employer or shall affect or impair any terms of employment with any Employer, the right of any Employer to control its employees, and the right of any Employer to terminate the service of any employee at any time, subject to applicable provisions of law and applicable collective bargaining agreements.

§ 14-704 Information to be Furnished.

Participants shall provide the Employer and the 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.

§ 14-705 Delegation of Authority by Employer.

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

§ 14-706 Interpretation.

This Plan is designed to satisfy the requirements of Code § 125 for a cafeteria plan. Unless a contrary intent shall appear herein, all terms used in this Plan shall be interpreted in the same manner as corresponding terms are used in Code § 125 and the regulations thereunder.

§ 14-707 Construction.

This Plan shall be construed and administered according to the laws of the United States of America and the Commonwealth of Pennsylvania. Further, this Plan shall be construed and administered so as to conform to the requirements for qualification under Code § 125 and shall be deemed amended automatically to conform to such legal requirements as in effect from time to time to the extent necessary.

§ 14-708 Gender and Number.

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

§ 14-709 Headings.

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

§ 14-710 Severability.

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

SECTION 2. The Codified Ordinances are hereby amended by adding the following new Chapter 20:

Chapter 20 — Medical Expense Reimbursement Plan

Article I — Title, Establishment, and General Definitions

§ 20-101 Short Title.

This Chapter shall be known, and may be cited, as the "Borough of Alburtis Medical Expense Reimbursement Plan."

§ 20-102 Establishment.

The Borough of Alburtis hereby establishes a Medical Expense Reimbursement Plan in order to provide certain employees with reimbursements of certain qualifying medical care expenses that are excludable from gross income under Section 105(b) of the Internal Revenue Code of 1986. The Plan is intended to qualify as a medical expense reimbursement program under Section 105(b) of the Internal Revenue Code of 1086, an employer-provided accident or health plan under Section 106(a) of the Internal Revenue Code of 1986, and a qualified health flexible spending arrangement under the regulations promulgated with respect to Section 125 of the Internal Revenue Code of 1986, as they may be amended from time to time, and is to be interpreted in a manner consistent with the requirements of those provisions.

§ 20-103 Definitions—In General.

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

§ 20-104 Administrator.

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

§ 20-105 Cafeteria Plan.

The term "Cafeteria Plan" shall mean the mean the Borough of Alburtis Cafeteria Plan under Chapter 14, as amended from time to time.

§ 20-106 Code.

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

§ 20-107 Coverage Amount.

For any Participant in any Plan Year, the term "Coverage Amount" shall mean the amount of medical expense reimbursement coverage elected by the Participant under the Cafeteria Plan.

§ 20-108 Dependent.

The term "Dependent" means, with respect to any Participant, any individual who is a dependent of the Participant within the meaning of Code § 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof). In addition, any child to whom Code § 152(e) applies (relating to special rule for divorced parents) shall be treated as a "Dependent" of both parents.

§ 20-109 Effective Date.

The "Effective Date" of this Plan is February 1, 2007.

§ 20-110 Employer.

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

§ 20-111 Grace Period.

The term "Grace Period" with respect to any Plan Year of this Plan, shall mean the period from January 1 through March 15 immediately following the end of the Plan Year.

§ 20-112 Participant.

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

§ 20-113 Plan.

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

§ 20-114 Plan Year.

The term "Plan Year" shall mean any 12 consecutive month period beginning on January 1 and ending on the following December 31. However, the first Plan Year under this Plan shall be the period from February 1, 2007 through December 31, 2007, inclusive.

§ 20-115 Qualified Employee.

The term "Qualified Employee" shall mean, as of any given date, any person who is receiving remuneration for personal services rendered to the Employer (other than as an independent contractor) and whose cus-

tomary employment is at least thirty-five (35) hours per week, *provided* such person is neither—

(a) a nonresident alien who receives no remuneration from the Employer which constitutes income from sources within the United States (within the meaning of the Code); nor

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

§ 20-116 Qualifying Medical Care Expenses.

(a) In General. Except as provided otherwise in this § 20-116, the term "Qualifying Medical Care Expenses" means expenses incurred by a Participant, his/her spouse, or Dependent, for Medical Care of the Participant, his spouse, or Dependent. Qualifying Medical Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

(b) Medical Care. For purposes of this § 20-116, the term "Medical Care" shall mean amounts paid (within the meaning of Code § 213(d) and the regulations and rulings thereunder):

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

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

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

no significant element of personal pleasure, recreation, or vacation in the travel away from home.

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

(1) any expenses to the extent that the Participant or other person incurring them is reimbursed or entitled to reimbursement for the expense through insurance or otherwise (other than under this Plan); *or*

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

§ 20-117 Related Employer.

The term "Related Employer" shall mean any—

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

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

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

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

§ 20-118 Sponsor.

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

Article II — Participation and Level of Coverage

§ 20-201 Commencement of Participation.

Every Qualified Employee shall become eligible to participate in the Plan on the date he becomes a participant in the Cafeteria Plan. An eligible Qualified Employee will become a Participant in this Plan on the effective date of a valid election under the Cafeteria Plan to receive Medical Expense Reimbursement coverage under this Plan.

§ 20-202 Cessation of Participation.

(a) In General. Except as otherwise provided in this § 20-202, a Participant will cease to be a Participant as of the date on which his election under the Cafeteria Plan to receive Medical Expense Reimbursement under this Plan expires or is terminated.

(b) Termination of Election Due to Loss of Status as a Cafeteria Plan Participant. If a Participant's election under the Cafeteria Plan terminates under § 14-308 (relating to Automatic Termination of election due to loss of status as a participant in the Cafeteria Plan and a Qualified Employee), the Participant will continue to be a Participant in this Plan until the *earlier* of—

(1) fourteen (14) calendar days after the termination of the Participant's Cafeteria Plan election, *or*

(2) the end of the Plan Year in which the termination occurred,

unless further extended under subsection (c).

(c) Continuation of Coverage. If a Participant is eligible to elect to continue coverage under the provisions of § 20-205(a), and elects to do so in a timely manner, the Participant will continue to be a Participant until the end of the then-current Plan Year.

(d) Termination of Plan. Notwithstanding anything to the contrary contained in this § 20-202, a Participant will cease to be a Participant in this Plan no later than the date as of which this Plan is terminated.

§ 20-203 Reinstatement of Former Participant.

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

§ 20-204 Level of Coverage.

A Participant may elect to receive coverage under this Plan for any Plan Year in any Coverage Amount up to Two Thousand Six Hundred Dollars ($2,600.00). Except as otherwise provided in this Chapter, all rules concerning elections by a Participant to receive, modify, or terminate coverage under this Plan are as stated in the Cafeteria Plan, which is incorporated herein by reference.

§ 20-205 Continuation of Coverage.

(a) Contributions to the Plan Exceed Reimbursements Received. If a Participant's election under the Cafeteria Plan terminates under § 14-308 (relating to Automatic Termination of election), and as of the date the Participant ceased to be a Qualified Employee the amount contributed to this Plan on behalf of the Participant for the Plan Year in which the election terminated exceeds the amount of reimbursements already made to the Participant from his Medical Expense Reimbursement Account for that Plan Year, the Participant may elect to continue coverage as a Participant under this Plan through the end of that Plan Year, *provided* that he agrees to pay bi-weekly premiums to this Plan through the end of that Plan Year at the same times and in the same amounts as the bi-weekly salary reduction which would have been made under § 14-303(b)(2) for coverage in this Plan under the Cafeteria Plan if the Participant had remained a participant in the Cafeteria Plan and an employee of the Employer. Any such agreement to pay premiums to this Plan shall be on a form provided by the Plan, may not be revoked, and shall provide that the Plan may collect any delinquent payments. The Participant may not terminate such continued coverage under this Plan and his obligation to make premium payments to this Plan simply by ceasing to pay the required pre-

miums when due. The election under this § 20-205(a) must be made no later than due date of the first bi-weekly premium payment for the continued coverage.

(b) COBRA Continuation Coverage. The Employer is not obligated to provide COBRA continuation coverage under this Plan because it normally employs fewer than twenty employees. 42 U.S.C. § 300bb-1(b)(1); Treas. Regs. § 54.4980B-2 (Q&A 5). However, if the number of employees should increase or the legal requirements change such that the continuation coverage rules do apply to this Plan, this Plan shall provide such coverage to the extent required by law and elected by the qualified beneficiaries, subject to the payment of periodic premiums in an amount equal to the current Coverage Amount (without reduction for any reimbursements previously paid) divided by the portion of the Plan Year for which a particular premium payment provides continuation coverage.

Article III — Medical Expense Reimbursement Accounts

§ 20-301 Establishment of Accounts.

The Employer will establish and maintain on its books a Medical Expense Reimbursement Account for each Plan Year with respect to each Participant who has elected under the Cafeteria Plan to receive Medical Expense Reimbursement coverage under this Plan for the Plan Year.

§ 20-302 Crediting of Accounts.

(a) In General. As of the first day of each Plan Year, the Medical Expense Reimbursement Account for that Plan Year of each Participant who elected coverage under this Plan for that Plan Year shall be credited with an amount equal to the Participant's Coverage Amount for such Plan Year, as in effect on the first day of the Plan Year.

(b) Mid-Year Entrants. If a person becomes a Participant in this Plan after the beginning of a Plan Year, the Participant's Medical Expense

Reimbursement Account for that Plan Year shall be credited, as of the date he becomes a Participant, with an amount equal to the Participant's Coverage Amount for such Plan Year as in effect on the date he becomes a Participant. This subsection (b) shall only apply the first time a person becomes a Participant in any Plan Year.

(c) Mid-Year Increases in Coverage. If the Coverage Amount of a Participant for any Plan Year increases at any time due to a change in coverage permitted under the terms of the Cafeteria Plan and elected by the Participant or imposed by the Administrator, the Participant's Medical Expense Reimbursement Account for that Plan Year shall be credited, as of the effective date of the change in coverage, with an amount equal to the difference between Participant's Coverage Amount for such Plan Year as in effect after the change and the Participant's Coverage Amount for such Plan Year as in effect immediately before the change.

(d) Credits Remain Property of Employer Until Paid. All amounts credited to a Medical Expense Reimbursement Account shall be and remain the property of the Employer until paid out pursuant to Article IV.

§ 20-303 Debiting of Accounts.

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

(b) Mid-Year Decreases in Coverage. If the Coverage Amount of a Participant for any Plan Year decreases at any time due to a change in coverage permitted under the terms of the Cafeteria Plan or this Plan, and elected by the Participant or imposed by the Administrator, an amount equal to the difference between Participant's Coverage Amount for such Plan Year as in effect before the change and the Participant's Coverage Amount for such Plan Year as in effect immediately after the change shall be debited from the Participant's Medical Expense Reimbursement Account for that Plan Year as of the effective date of the change in coverage.

§ 20-304 Forfeiture of Accounts.

(a) In General. The amount credited to a Participant's Medical Expense Reimbursement Account for any Plan Year shall be used only to reimburse the Participant for Qualifying Medical Care Expenses—

(1) incurred—

(A) during such Plan Year and while he was a Participant; *or*

(B) during the Grace Period for such Plan Year *if* the Participant was a Participant on the last day of the Plan Year; *and*

(2) submitted to the Plan for reimbursement during such Plan Year or within three (3) months after the close of such Plan Year.

An expense is incurred on the date services are rendered, regardless of when the services are billed or paid.

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

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

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

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

(4) such balance shall remain the property of the Employer, and be applied in accordance with § 20-305.

§ 20-305 Application of Forfeitures.

(a) Net Experience Gains. For purposes of this § 20-305, the Plan shall recognize a "net experience gain" for a Plan Year whenever the

total amount of reimbursements paid from the Medical Expense Reimbursement Accounts of Participants for the Plan Year exceeds the total amount of contributions made by or on behalf of the Participants for coverage under this Plan for the Plan Year, whether through compensation reductions under the Cafeteria Plan or through payments of required premiums for continued coverage under § 20-205. The amount of the "net experience gain" shall be equal to the difference between the amount of contributions received and the reimbursements paid. Net experience gains result from forfeitures from the accounts of Participants, less plan losses for Participants who received more reimbursements than the contributions they paid for the coverage (*e.g.*, due to termination of employment during the Plan Year).

(b) Application of Net Experience Gains. If there is a net experience gain for any Plan Year, the amount of the net experience gain shall be used to reimburse claims incurred in the following Plan Year above the amounts elected by Participants for that Plan Year. (*Cf.*, Prop. Treas. Regs. § 1.125-2 Q&A 7(b)(7); ERISA Tech. Rel. 92-01, final paragraph). All forfeitures for a given Plan Year (the "**Forfeiture Year**") shall be effective as of April 1 of the following Plan Year (the "**Application Year**"). If there are any net experience gains for the Forfeiture Year, the Medical Expense Reimbursement Account for the Application Year of each person who is a Participant on April 1 of the Application Year shall be credited with an amount equal to:.

(1) the net experience gains for the Forfeiture Year; *multiplied by*

(2) a fraction—

(A) whose numerator is the Coverage Amount under this Plan elected by the particular Participant for the Application Year (as modified by any permitted changes effective on or before April 1 of the Application Year); *and*

(B) whose denominator is the total of the Coverage Amounts under this Plan elected by all Participants for the Application Year (as modified by any permitted changes effective on or before April 1 of the Application Year).

These additional credits shall be effective as of April 1 of the Application Year.

Article IV — Benefits

§ 20-401 Claims for Reimbursement.

Subject to the procedures and limitations set forth in this Article IV, a Participant who has elected to receive Medical Expense Reimbursement coverage under this Plan for a Plan Year shall be entitled to receive reimbursement of Qualifying Medical Care Expenses incurred by the Participant, his/her spouse, or his/her Dependents—

(a) during the Plan Year and while the Participant is a Participant, *or*

(b) during the Grace Period for such Plan Year *if* the Participant was a Participant on the last day of the Plan Year.

§ 20-402 Application for Reimbursement.

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

(1) the amount and nature of the expense;

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

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

(4) the date that the expense was paid;

(5) the name of the person for whom the expense was incurred, together with an identification of that person as the Participant, the spouse of a Participant, or a Dependent of a Participant;

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

(7) 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*

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

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

(1) a written statement from an independent third party, stating that the expense has been incurred and the amount of the expense; *and*

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

(c) Time of Application.

(1) Earliest Submission of Reimbursement Applications. An application for reimbursement of Qualifying Medical Care Expenses under this Plan may not be filed until after all services covered by the application have been rendered *and* paid for.

(2) Latest Submission of Reimbursement Applications. All applications for reimbursement of Qualifying Medical Care Expenses for services rendered during any given Plan Year (or for services rendered in the Grace Period for a Plan Year where the reimbursement is requested from the Medical Expense Reimbursement Account for that Plan Year) shall be submitted no later than three (3) calendar months after the end of the Plan Year.

§ 20-403 Time of Reimbursement.

Reimbursements under this Plan shall be made at such time and in such manner as the Administrator may prescribe, but no less frequently than monthly. The Administrator need not make any particular reimbursement until an administratively reasonable period after a Participant or Continuation Coverage Participant submits an appropriate application and documentation under § 20-402.

§ 20-404 Limitation Based on Amount in Participant's Medical Expense Reimbursement Account.

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

§ 20-405 No Reimbursement While Required Premium Payments Are In Default.

No reimbursement shall be made from this Plan of Qualifying Medical Care Expenses of a Participant at any time that the Participant is in default with respect to the payment of any required premiums to this Plan under § 20-205(a) (relating to continuation of coverage). After the person cures all such defaults, reimbursements may be made in accordance with the provisions and limitations of this Article IV.

§ 20-406 Limitation on Reimbursements or Payments With Respect to Certain Participants.

Notwithstanding any other provision of this Plan, the Administrator may limit, temporarily, the amounts to be reimbursed or paid under this Plan to the extent directed by the plan administrator of the Cafeteria Plan to assure compliance with the overall limitations on benefits for "key employees" under the Cafeteria Plan. If, after the end of any Plan Year, the Administrator determines that any Qualifying Medical Care Expenses in-

curred during such Plan Year cannot be reimbursed due to restrictions imposed under the Cafeteria Plan for "key employees" as allocated to this Plan by the plan administrator of the Cafeteria Plan, and any balance remains in a person's Medical Expense Reimbursement Account for such Plan Year after all the permissible reimbursements under this Plan (and after taking into account the restrictions under the Cafeteria Plan), then, notwithstanding the fact that there are sufficient amounts in the person's Medical Expense Reimbursement Account to pay all or part of the remaining Qualifying Medical Care Expenses submitted for reimbursement—

(a) the balance in the person's Medical Expense Reimbursement Account for such Plan Year shall *not* be carried over to reimburse the person for any Qualifying Medical Care Expenses incurred during a subsequent Plan Year;

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

(c) the person shall forfeit all rights with respect to such balance; *and*

(d) such balance shall remain the property of the Employer, and be applied in accordance with § 20-305.

§ 20-407 Termination of Participation.

After a person shall cease to be a Participant, he/she is still entitled to reimbursement for Qualifying Medical Care Expenses incurred while he/she was a Participant, subject to the procedures and limitations set forth in this Article IV, but shall not be entitled to reimbursement for Qualifying Medical Care Expenses incurred after the date his/her participation terminates, except as provided in § 20-401(b) (relating to Grace Period). In the event of the Participant's death, the Participant's spouse (or, if none, the Participant's personal representative) may apply on the Participant's behalf for reimbursements permitted under this Article IV.

Article V — Claims Procedure

§ 20-501 Filing a Claim.

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

§ 20-502 Notice of Denial.

If the Administrator denies a request for benefits under § 20-402 or § 20-501 in whole or in part, it shall notify the claimant of the same in writing within 60 days of the date the request was filed with the Administrator. Any notice of denial shall contain—

(a) the reason for the denial;

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

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

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

If such notification is not given within the above 60 day period, the claimant may consider the claim denied as of the last day of such period.

§ 20-503 Review of Denial.

(a) Petition. A claimant may petition the Administrator in writing for a review of the denial of any claim within 60 days after the receipt of a notice of denial under § 20-502, or at any time after the claimant may consider his claim denied under § 20-502 and before the claimant receives a formal notice from the Administrator under § 20-502.

(b) Rights. With respect to any review 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 § 20-502; *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 § 20-503 within 60 days following its receipt of a petition for such review under subsection (a). 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 under this § 20-503 shall comply with the provisions of the Local Agency Law, 2 PA. CONS. STAT. § 551 *et seq*.

Article VI — Administration

§ 20-601 In General.

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

§ 20-602 Powers and Duties.

(a) In General. The Administrator shall administer the Plan in accordance with its terms, and shall have all powers necessary to carry out the provisions of the Plan. The Administrator shall have absolute and exclusive discretion to decide all issues arising in the administration, interpretation, and application of the Plan. The Administrator may from time to time set forth rules of interpretation and administration, subject to modification as appropriate in the light of experience. Decisions and rules established by the Administrator shall be conclusive and binding on all

persons. The Administrator shall act without discrimination among persons similarly situated at any given time, although it may change its policies from time to time, and shall always act in the exclusive interest of Plan Participants and their beneficiaries. However, the Administrator's authority under this Article VI shall not extend to any matter as to which the Administrator of the Cafeteria Plan is empowered to make determinations under the Cafeteria Plan.

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

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

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

(e) Reports, Documents, and Communications. The Administrator shall prepare and file all reports and documents required to be filed with a governmental agency, shall prepare and provide or make available all reports and documents required to be provided or made available to Participants or persons with an interest under the Plan, and shall commu-

nicate with employees and other persons with respect to all matters relating to the Plan, including rights and benefits under this Plan.

(f) HIPAA. Under current law, the HIPAA requirements of Code § 9801 *et seq*. do not apply to this Plan pursuant to Code § 9831(a), and the HIPAA privacy rules do not apply to this Plan because it is a self-administered group health plan with fewer than fifty participants.

§ 20-603 Indemnification.

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

§ 20-604 Benefits Solely From General Assets.

Except as may otherwise be required by law—

(a) any amount by which a Participant's compensation is reduced under the Cafeteria Plan or this Plan to provide coverage under this Plan or which is paid to this Plan under § 20-205 (relating to continuation of coverage) will remain part of the general assets of the Employer;

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

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

§ 20-605 Spendthrift Provisions.

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

§ 20-606 Facility of Payment.

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

Article VII — Amendment and Termination

§ 20-701 Amendment of Plan.

The Employer reserves the right to amend this Plan to any extent and in any manner that it may deem advisable at any time by ordinance of the Sponsor.

§ 20-702 Termination of Plan.

Although the Employer has established this Plan with the bona fide intention and expectation to continue this Plan indefinitely, the Employer will have no obligation whatsoever to maintain the Plan for any given length of time, and the Employer reserves the right to terminate this Plan at any time by ordinance of the Sponsor, without liability.

Article VIII — Tax Implications

§ 20-801 No Guarantee of Tax Consequences.

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

§ 20-802 Indemnification of Employer by Participants.

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

Article IX — Miscellaneous

§ 20-901 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.

§ 20-902 Limitation of Liability.

Each person who becomes a Participant under this Plan expressly agrees and understands that neither the Employer, the Administrator, 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.

§ 20-903 Employment Rights.

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

§ 20-904 Information to be Furnished.

Participants shall provide the Employer and the 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.

§ 20-905 Delegation of Authority by Employer.

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

§ 20-906 Interpretation.

This Plan is designed to satisfy the requirements of Code § 105(b) for a medical expense reimbursement program, Code § 106(a) for an employer-provided accident or health plan, and Proposed Treasury Regulations § 1.125-2 (Q&A 7) (except as it may be superseded by later proposed or final regulations) for a qualified health flexible spending arrangement. Unless a contrary intent shall appear herein, all terms used in this Plan shall be interpreted in the same manner as corresponding terms are used in those provisions and the regulations, rulings, and interpretations issued thereunder.

§ 20-907 Construction.

This Plan shall be construed and administered according to the laws of the United States of America and the Commonwealth of Pennsylvania. Further, this Plan shall be construed and administered so as to conform to the requirements for qualification under Code §§ 105(b) and 106(a), and the regulations thereunder, and Prop. Treas. Regs. § 1.125-2 (Q&A 7) (except as it may be superseded by later proposed or final regulations), and shall be deemed amended automatically to conform to such legal requirements as in effect from time to time to the extent necessary.

§ 20-908 Gender and Number.

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

§ 20-909 Headings.

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

§ 20-910 Severability.

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

SECTION 3. Chapter 12, Article IV of the Codified Ordinances (relating to Personnel Policies—Benefits) is amended by adding the following new § 12-405.1 after existing § 12-405:

§ 12-405.1 Medical Expense Reimbursement Plan.

The Borough offers a Medical Expense Reimbursement Plan (*see* Chapter 20) to provide a means (together with the Cafeteria Plan described in Chapter 14) for eligible employees to elect to make contributions to the Plan with pre-tax dollars and receive reimbursements from the Plan for certain qualifying medical care expenses, rather than paying for such expenses with after-tax dollars.

DULY ORDAINED and **ENACTED** by the Borough Council of the Borough of Alburtis, this 10th day of January, 2007, in lawful session duly assembled.

BOROUGH COUNCIL
BOROUGH OF ALBURTIS

_____
Steven R. Hill, President

Attest:

_____
Melanie Hansen, Executive Secretary

AND NOW, this 10th day of January, 2007, the above Ordinance is hereby APPROVED.

_____
Russell J. Afflerbach, Mayor