Chapter 14 — Cafeteria Plan

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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.

§ 14-105.1 Dental Plan.

The term "Dental Plan" shall mean the dental plan provided from time to time under § 12-405(a) (relating to Personnel Policies—Benefits—Dental and Vision Coverage—Dental Coverage). As of January 1, 2022, the Dental Plan is the product known as Capital Blue Cross Dental PPO Plus, as offered to the Borough of Alburtis and renamed from time to time by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross which takes over that product), but the specific plan and/or the coverages available under the plan may change from time to time.

§ 14-106 Effective Date.

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

§ 14-107 Eligibility Month.

The term "Eligibility Month" means the third calendar month following the calendar month in which an employee commences employment with the Employer as a Qualified Employee, *provided* that the employee remained a Qualified Employee continuously through the beginning of the Eligibility Month. Except as provided in § 14-203 (relating to Reinstatement of Former Participant within the same Plan Year), a person who was a Qualified Employee, then ceased to be a Qualified Employee, and who again becomes a Qualified Employee, 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 January 1, 2022, the Health Plan is the product known as Gold PPO 2000/0/20 Rx 0, as offered to the Borough of Alburtis and renamed from time to time by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross which takes over that product), but the specific plan and/or the coverages available under the plan may change from time to time.

§ 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 as an employee (within the meaning of Code § 125 and the regulations thereunder) and not 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 Employee.

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.

§ 14-118 Vision Plan.

The term "Vision Plan" shall mean the vision plan provided from time to time under § 12-405(b) (relating to Personnel Policies—Benefits—Dental and Vision Coverage—Vision Coverage). As of January 1, 2022, the Vision Plan is the product known as Capital Blue Cross Vision 12/10 Plus, as offered to the Borough of Alburtis and renamed from time to time by Capital Advantage Assurance Company (or other affiliate of Capital Blue Cross which takes over that product), but the specific plan and/or the coverages available under the plan may change from time to time.

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

Article III — Election of Optional Benefits

§ 14-301 Coverage Options.

Except to the extent that a Participant is restricted from waiving or selecting certain options for Health Plan coverage under § 12-403 (relating to Personnel Policies—Benefits—Health & Hospitalization) or corresponding provisions of the current collective bargaining agreement for police officers, 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, the Participant must also elect whether the coverage will be for the Participant only, or the coverage will be for the Participant and one or more additional persons specifically identified (by name and date of birth) by the Participant from among the Participant's spouse and his/her eligible children.

(b) The Medical Expense Reimbursement Plan.

(c) The Dental Plan. Since the Dental Plan is already provided by the Borough to full-time nonuniformed employees and the Chief of Police at no cost, this option is only available to full-time police officers.

(d) The Vision Plan. Since the Vision Plan is already provided by the Borough to full-time nonuniformed employees and the Chief of Police at no cost, this option is only available to full-time police officers.

§ 14-302 Description 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, the Dental Plan, the Vision 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 or Cash Bonuses in Lieu of Coverage.

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 (and not precluded under § 12-403 (relating to Personnel Policies—Benefits—Health & Hospitalization) or corresponding provisions of the current collective bargaining agreement for police officers, 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(b.1) (relating to Personnel Policies—Benefits—Health & Hospitalization—Employee Contributions to Premiums) or corresponding provisions of the current collective bargaining agreement for police officers. 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 be reduced from any given paycheck for the Health Plan shall be equal to the amount which the Participant must contribute for that payday under § 12-403(b.1) (relating to Personnel Policies—Benefits—Health & Hospitalization—Employee Contributions to Premiums) or corresponding provisions of the current collective bargaining agreement for police officers.

(3) Payment of Additional Cash in Lieu of Coverage. If a Participant is eligible under § 12-403(c) (relating to Personnel Policies—Benefits—Health & Hospitalization—Waiver of Coverage) or corresponding provisions of the current collective bargaining agreement for police officers to waive coverage under the Health Plan and receive cash payments in the amount set forth therein, and the Participant so elects to waive coverage and receive the cash payments for a Plan Year, the Employer will make cash payments each month to the Participant in the amount so set forth via contributions made through this Plan and credited to the Participant. The payments will be included in the first paycheck issued to the Participant in that month, less any applicable taxes and other deductions. The Participant will not receive any coverage under the Health Plan for any such month.

(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.

(c) Dental Plan. If a Participant elects coverage for a Plan Year under the Dental 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 Dental Plan coverage with respect to the paydays during the Plan Year. The amount of the required contribution for the first payday in each calendar month and for the second payday in each calendar month is one-half of the premium charged to the Borough to provide coverage for the Participant for that calendar month. The amount of compensation to be reduced from any given paycheck for the Dental Plan shall be equal to the amount which the Participant must contribute for that payday.

(d) Vision Plan. If a Participant elects coverage for a Plan Year under the Vision 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 Vision Plan coverage with respect to the paydays during the Plan Year. The amount of the required contribution for the first payday in each calendar month and for the second payday in each calendar month is one-half of the premium charged to the Borough to provide coverage for the Participant for that calendar month. The amount of compensation to be reduced from any given paycheck for the Vision Plan shall be equal to the amount which the Participant must contribute for that payday.

§ 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 Proper 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 (or submission of an election form that selects an option or waiver that the Participant is not permitted to make) on or before the due date for any Plan Year after the first Plan Year of this Cafeteria Plan shall constitute—

(A) if the Participant is eligible to make an election under § 12-403(c) (relating to Personnel Policies—Benefits—Health & Hospitalization—Waiver of Coverage) or corresponding provisions of the current collective bargaining agreement for police officers: 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 to the Participant under the

Health Plan, § 12-403(c) or corresponding provisions of the current collective bargaining agreement for police officers, and this Cafeteria Plan), and a re-election of any election to waive Health Plan coverage and receive cash in lieu of coverage which was in effect just prior to the end of the Preceding Plan Year. If the Participant had coverage under the Health Plan just prior to the end of the preceding Plan Year but the coverage option is no longer available to the Participant, then there shall be a deemed election of coverage for only the Participant under the Health Plan;

(B) if the Participant is not eligible to make an election under § 12-403(c) or corresponding provisions of the current collective bargaining agreement for police officers: 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 to the Participant under the Health Plan, § 12-403(c) or corresponding provisions of the current collective bargaining agreement for police officers, and this Cafeteria Plan), but if there is no such coverage or coverages, then an election of coverage for only the Participant under the Health Plan.

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

(a) In General.

(1) Elections Are Ordinarily Irrevocable. 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.

(2) Restriction on Changes to Elections Under the Medical Expense Reimbursement Plan. Notwithstanding anything to the contrary in this § 14-305, a Participant may not revoke an election for the balance of the Plan Year and/or file a new election for the balance of the Plan Year unless 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.

(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); *and*

(C) the change is consistent with the terms of the plan(s) in question.

(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 dependent, 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. In the case of coverage under the Health Plan, a Participant may revoke an election and file a new election for the balance of the Plan Year as follows, all in accordance with the provisions regarding special enrollment rights and special enrollment periods under Code § 9801(f), Public Health Service Act § 2701(f), 42 U.S.C. § 300gg-3(f), Treas. Regs. § 54.9801-6, and 45 CFR § 146.117.

(1) Certain Individuals Who Lose Coverage.

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

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

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

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

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

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

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

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

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

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

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

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

(C) Conditions for Special Enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) Special Rules Relating to Medicaid or CHIP.

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

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

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

(III) either—

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

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

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

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

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

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

(III) either—

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

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

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

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

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

(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) 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" means a person who is either—

(1) a "dependent" of the Participant as defined in Code § 152 (determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), except that any child to whom Code § 152(e) applies is treated as a dependent of both parents;

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

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

§ 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, the Dental Plan, and/or the Vision 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, Dental Plan, and Vision Plan. The elections for coverage under the Health Plan, the Dental Plan, and the Vision 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 corresponding 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 (*i.e.*, salary reductions) under the Plan for any Participant for any Plan Year shall be the maximum coverage amount which the Participant may select for the Plan Year under the Medical Expense Reimbursement Plan ($2,500.00 for persons eligible under that plan), plus the Participant's share of the cost of the most expensive coverage(s) available to the Participant under the Health Plan, the Dental Plan, and the Vision Plan for the Plan Year, plus the maximum amount of cash payments available to the Participant if the Participant were to waive coverage under the Health Plan.

§ 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, Dental Plan, Vision 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 administra-

tion, 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, notwithstanding the foregoing, any claim which arises under the Health Plan, the Dental Plan, the Vision 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, the Dental Plan, the Vision 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 communicate 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, the Dental Plan, and/or the Vision 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, the Dental Plan, the Vision 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, the Dental Plan, the Vision 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, the Dental Plan, the Vision 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 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.

§ 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.

Appendix

¶ 14-A Source Ordinances.

Ordinance 454	01-10-2007
Ordinance 458	02-28-2007
Ordinance 469	12-26-2007
Ordinance 476	12-29-2008
Ordinance 501	12-28-2011
Ordinance 515	12-23-2013
Ordinance 524	12-29-2014
Ordinance 525	01-14-2015

Ordinance 568 12-08-2021