ALBURTIS CODIFIED ORDINANCES

Chapter 20

Medical Expense Reimbursement Plan

Chapter 20 — Medical Expense Reimbursement Plan

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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 1986, 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 either—

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

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

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

§ 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 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.

§ 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;

(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), including but not limited to reimbursements available under the health/medical/hospitalization plan of the Employer under § 12-403, the dental and vision plans under § 12-405, and the health reimbursement arrangements under Chapters 20A, 20B, and 20C. Any deductibles under these health reimbursement arrangements that are not reimbursed or entitled to reimbursement through insurance or otherwise (other than under this Plan) are not excluded under this paragraph (1); *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(b.1) (relating to Personal Policies—Benefits—Health & Hospitalization—Employee Contributions to Premiums);

(3) any expenses for qualified long-term care services (as defined in Code § 7702B(c));

(4) any expenses for cosmetic surgery (any procedure which is directed at improving the patient's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease) or other similar procedure, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease; *or*

(5) any expenses for a medicine or drug, unless the medicine or drug is a prescribed drug (determined without regard to whether such drug is available without a prescription) or is insulin.

§ 20-117 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.

§ 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 Five Hundred Dollars ($2,500.00). 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 premiums 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.

(1) Federal COBRA. The Employer is not obligated to provide federal COBRA continuation coverage under this Plan because it normally employs fewer than twenty employees. 42 U.S.C. § 300bb-1(b)(1); Treas. Regs. § 54.4980B-2 (Q&A 5). In addition, under Treas. Regs. § 54.4980B-2 (Q&A 8(d)), COBRA continuation coverage in this Plan is not required after the Plan Year of the qualifying event, and under Treas. Regs. § 54.4980B-2 (Q&A 8(e)), COBRA continuation coverage in this Plan is not required for the Plan Year of the qualifying event beyond what is provided under subsection (a) of this § 20-205. However, if the number of employees should increase or the legal requirements change such that the 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.

(2) Pennsylvania Mini-COBRA. The Employer is also not obligated to provide the shorter-duration Pennsylvania mini-COBRA continuation coverage under this Plan because it is a self-insured plan and not group policy issued by an "insurer". 40 PA. STAT. ANN. § 764j(g)(4), (5). However, if the legal requirements change such that the Pennsylvania mini-COBRA continuation coverage rules do apply to this Plan, this Plan shall provide such coverage to the extent required by law and elected by the covered employee and/or eligible dependent, subject to the payment of periodic premiums equal to the current Coverage Amount (without reduction for any reimbursements previously paid) divided by the portion of the Plan Year for which a particular premium payment provides continuation coverage.

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 retained by the Employer in accordance with Treas. Regs. § 1-125-5(o)(1)(i).

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 providing information describing the service or product, the date of the service or sale, and the amount (including, but not limited to, statements from a provider, and an explanation of benefits from an insurance company); *and*

(2) such other bills, invoices, prescriptions or other documentation showing that a prescription has been issued for the item purchased, 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 incurred 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.

§ 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 communicate 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 VIIIA — HIPAA Privacy and Security Practices

§ 20-821 In General.

This Plan is not subject to the administrative simplification provisions, the privacy rule, or the securcity rule of the Health Insurance Portability and Accountability Act of 1996, as amended, because it has fewer than fifty (50) participants (as defined in section 3(7) of ERISA, 29 U.S.C. § 1002(7) and is self-administered by the Employer. *See* 45 CFR §§ 160.102(a) and 160.103 (definitions of health plan and group health plan).

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 the regulations under Code § 125 for a qualified health flexible spending arrangement offered through 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 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 the regulations under Code § 125 for a qualified health flexible spending arrangement offered through a cafeteria plan, 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.

Appendix

¶ 20-A Source Ordinances.

Ordinance 454	01-10-2007
Ordinance 515	12-23-2013
Ordinance 524	12-29-2014
Ordinance 525	01-14-2015
Ordinance 526	01-28-2015
Ordinance 528	03-11-2015