Summary Plan Description

of the

Medical Expense Reimbursement Plan

for Employees of
Moravian College

A Message to our Employees

This document is called a "Summary Plan Description." Its purpose is to explain the provisions of the Moravian College Medical Expense Reimbursement Plan (the "Plan"). You are urged to read this Summary Plan Description carefully.

The benefits of this plan are closely connected to the benefits that you are eligible for under the Moravian College Health Plan. Copies of the Summary Plan Description for this plan have been provided to you. Additional copies are available upon your request.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend this Plan at any time for any reason.

If you have any questions about your benefits under this Plan, please contact the Employer.

Last Modified: 10/30/12

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Section 1: General Information about the Plan

Plan Name:		Medical Expense Reimbursement Plan for the Employees of Moravian College
Type of Plan:		Welfare plan providing medical coverage as a medical expense reimbursement plan
Plan Year:		January 1st through December 31st
Plan Number:		501 This plan also includes other health care benefits that are described in a separate plan document.
Effective Date:		January 1, 2007; This Plan has been amended and restated as of January 1, 2013
Plan Sponsor:		Moravian College 1200 Main Street Bethlehem, PA 18018 (610) 861-1526
Name and Address of Other Participating Affiliated Employers:		None
Plan Sponsor's Employer Identification number:		24-0795460
Plan Administrator:		Moravian College 1200 Main Street Bethlehem, PA 18018 (610) 861-1526
Named Fiduciary:		Jon Conrad, Director of Human Resources Moravian College 1200 Main Street Bethlehem, PA 18018 (610) 861-1526
Agent for Service of Legal Process:		Moravian College 1200 Main Street Bethlehem, PA 18018 (610) 861-1526 Attention: Jon Conrad
Plan Document:		This SPD constitutes the written plan document required by ERISA §402.

Section 2: Benefit Description

Maximum Reimbursement Amount		Eligible Employees enrolled in the Health Plan may be eligible for reimbursement of qualified medical in-network deductible expenses. Eligibility and the amount of the reimbursement amount will be calculated according to base earnings. Employees who earn in excess of $50,000 per year are ineligible for this Plan. The fund amount can be found on the attached summary that applies to expenses incurred the current Plan Year. All funds will be available at the beginning of each Plan Year, but only if in-network deductible expenses are incurred. <u>Mid-Year Enrollments</u> If an employee enrolls in the Health Plan in the middle of the Plan Year, the entire reimbursement amount shown on the attached summary will be available on the date of enrollment. <u>Claims Submission Period</u> All claims must be submitted no later than 3 months after the end of the Plan Year or 3 months after termination of coverage. Any amounts unused at the end of the Plan Year will be forfeited at the end of the claims submission period.
Eligible Expenses		In-network Deductible Expenses
Waiting Period for Eligibility		Employees and their Dependents, as defined by this plan, are eligible for coverage under this Plan on the later of January 1, 2007 or the day of their enrollment in the Health Plan.
Other Eligibility Requirements		Employees are eligible for coverage under this Plan only if they are active benefits-eligible Employees of the Employer and only if they have enrolled in the Health Plan. Employees who earn in excess of $50,000 are ineligible for benefits.
Participant Contributions		Participants are not required to contribute to the cost of coverage under this Plan.

Section 3: Purpose and Establishment of Plan

3.1 Purpose and Legal Status.
The purpose of this Plan is to reimburse Employees for Qualifying Medical Expenses not reimbursed by any other plan or taken as a tax deduction. It is intended that the Plan qualify as a self-insured medical reimbursement plan within the meaning of Section 105 of the Code and that the reimbursements paid under this Plan be eligible for exclusion from Participants' income under Section 105(b) of the Code.

3.2 Establishment.
The Employer established this Plan as of the Effective Date.

3.3 Name.
This Plan shall be named the Medical Expense Reimbursement Plan for Employees of Moravian College.

3.4 Plan Not Subject to Cafeteria Plan.
This Plan shall not be subject to the provisions of any Cafeteria Plan.

Section 4: Definitions

4.1 Administrator or Plan Administrator.
Administrator means the Employer. Contact information for the Plan Administrator is shown in Section 1. The contact person has the full authority to act on behalf of the Administrator.

4.2 Cafeteria Plan.
Cafeteria Plan means a cafeteria plan established for Employees of the Employer under § 125 of the Code.

4.3 Code.
Code means the Internal Revenue Code of 1986, as amended from time to time.

4.4 Dependent.
Dependent means a Participant's spouse or any individual who is the child of the Participant as defined in Code Section 152 (f)(1) and who is eligible for coverage under the Health Plan.

4.5 Employee.
Employee means any person regularly scheduled to work the hours shown in the Benefit Description in Section 2 of this Plan, rendering services to the Employer for remuneration, which is subject to federal income tax withholding and FICA taxes. However, the term "Employee" shall not include: (1) any leased employee, contract worker, independent contractor, temporary employee, or casual employee, whether or not such individual is on the Employer's W-2 payroll; (2) any person who performs services for the Employer but is paid by a staffing agency; (3) any self-employed individual; (4) any more than 2% shareholder in a sub-chapter S corporation, including those deemed to be a more than 2% shareholder based on the ownership attribution rules of Section 318 of the Code.

4.6 Employer.
Employer means Moravian College.

4.7 FMLA.
FMLA means the Family and Medical Leave Act of 1993, as amended.

4.8 Health Plan.
Health Plan means the PPO Select and PPO Choice employee welfare benefit plans which are designated by the Employer to include this Medical Expense Reimbursement Plan.

4.9 Participant.
Participant means an Employee who satisfies the requirements of Section 5.1 of the Plan and who is eligible for and elects coverage under the Health Plan.

4.10 Plan.
Plan means this Medical Expense Reimbursement Plan for Employees of Moravian College, as amended from time to time.

4.11 Plan Year.
Plan Year means the twelve-month period commencing on January 1st and ending on the last day of the following December.

4.12 Qualifying Medical Expenses.
Qualifying Medical Expenses shall have the meaning given to it in Section 7.5 of this Summary Plan Description.

4.13 Termination.
Termination means the termination of a Participant's employment as an Employee whether by reason of change, discharge, layoff, voluntary termination, disability, retirement, death or otherwise.

4.14 USERRA.
USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

Section 5: Eligibility and Termination

5.1 Employee Eligibility.
Generally, an Employee shall be eligible to participate in this Plan if the Eligibility Requirements shown in the Benefit Description are met and the Employee is enrolled in the Health Plan. All eligible employees who enroll in the Health Plan will automatically be enrolled in this Plan. Coverage will be effective under this Plan on the date that coverage is effective for the Participant under the Health Plan.

5.2 Enrollment Following Termination of Employment or Loss of Eligibility.
If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Participant will be reinstated in this Plan, pending reinstatement in the Health Plan, as explained in the certificate of coverage.

5.3 Termination of Participation in this Plan.

A Participant will cease to be a Participant in this Plan upon the earlier of:

- The termination of this Plan;
- The date on which the Employee ceases to be an eligible Employee, provided that eligibility may continue beyond such date for purposes of COBRA coverage;
- For a Dependent, the date the individual no longer qualifies as a Dependent or upon termination of the requirements of a Qualified Medical Child Support Order; or
- The date that the Employee or Dependent is no longer enrolled in the Health Plan.

Any expenses incurred by a Participant after termination of participation in this Plan will not be payable by this Plan, except as permitted in accordance with Section 5.8 below.

5.4 FMLA and USERRA Leaves of Absence.

Notwithstanding any provision to the contrary, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or the USERRA, as applicable, the Employer will continue to maintain the Participant's coverage on the same terms and conditions as if the Participant were still an active employee.

5.5 Dependent Eligibility.

A spouse or Dependent child of an Employee will become eligible for coverage on the later of the date that the Employee is eligible for coverage under this HRA Plan or the date the Dependent becomes a Dependent as defined by this HRA Plan.

This HRA Plan also will extend benefits to dependent children placed with a Participant for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of a Participant.

5.6 Coordination of Benefits; this Plan to Reimburse before a Flexible Spending Account

Benefits under this Plan are intended to pay benefits solely for Qualifying Medical Expenses not previously reimbursed or reimbursable elsewhere. However, if the Participant's or Dependent's Qualifying Medical Expense is payable only by this Plan and a health care flexible spending account, then this Plan would pay before reimbursement under the flexible spending account would be available.

5.7 Qualified Medical Child Support Orders.

An eligible Dependent child may include a child for whom a Participant is required to provide coverage pursuant to a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court or administrative judgment, decree or order that is typically issued as part of a divorce or as part of a state child support order proceeding and that requires health plan coverage for an "alternate recipient" (meaning either a child of a Participant or state or political subdivision acting on behalf of a child). The alternate recipient must be treated like any other Participant.

Upon receipt of a child support order, the Plan Administrator will promptly send a written notice of receipt of the order to the Participant and all alternate recipient children named in the order and their legal representatives. If the Plan Administrator receives a National Medical Support Notice, it will notify the state agency whether coverage for the child is available under the Plan and indicate the effective date of coverage (or any steps necessary to make the coverage effective, including copies of any forms that must be completed). The Plan Administrator will also send a description of the coverage.

After sending the notice of receipt, the Plan Administrator has the ultimate authority to determine whether or not the order meets the requirements of a QMCSO. Within 40 days after receiving the order, the Plan Administrator will notify the Participant and the alternate recipients that either the order is a valid QMCSO or that the order is not a valid QMCSO. If an order is found to be invalid, the parties may "cure" the deficiencies with a subsequent order.

5.8 COBRA Continuation Coverage.
If a Participant's or Dependent's coverage under this Plan terminates because of a "qualifying event," each individual has a right to purchase continued coverage for a temporary period of time. COBRA coverage is available under this Plan, only if the individual also elects COBRA under the Health Plan.

Qualifying events include termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of dependent. A Participant or Dependent who is covered under this Plan must notify the Plan Administrator of any divorce, legal separation, or a child ceasing to be considered a Dependent under the Plan within 60 days after the event. This notice must be in writing and addressed to the Plan Administrator. In addition, if a second qualifying event occurs during COBRA continuation coverage or if the former Employee becomes entitled to Medicare or dies during the COBRA coverage, the Participant or Dependent must notify the Plan Administrator. Finally, a Participant must notify the Plan Administrator of the start or end of any disability that is determined under the Social Security Act to be a covered disability. The Plan Administrator will provide Participants and Dependents with the forms needed to make the required notifications.

Any notice described in the above paragraph must be provided in writing to the Plan Administrator within 60 days of the occurrence of the applicable event (except that if there is a change in the Participant's disability status, notice must be given within 30 days). If the Participant or Dependent fails to provide notice within the required time period, he or she may no longer be eligible for COBRA continuation coverage. In this event, the Plan Administrator may send Notice of Unavailability of COBRA Coverage upon receipt of the late notice.

If you have any questions about your COBRA rights, please read the COBRA notice, which has been provided to you and your spouse (if covered) at the time of your enrollment in the Health Plan or a prior health plan sponsored by the Employer. You can contact the Plan Administrator if you need another copy.

Unless otherwise agreed to by the Employee and his or her Dependents in writing, all benefits will continue to be shared during any period of COBRA continuation coverage, even if only one individual has continued coverage.

Section 6: Changes to Elected Coverage

6.1 Voluntary Modification.
A Participant may change his participation election by changing his election under the Health Plan. Any changes made to an election under the Health Plan, including adding or removing a spouse or other Dependent, will automatically change the Participant's election under this Plan.

6.2 Administrative Modification.
The Plan Administrator may modify enrollment elections for administrative purposes or to comply with plan legal requirements.

6.3 Limitations on Elections of Highly Compensated Employees.
Elections of highly compensated employees may be limited or restricted to comply with any plan legal requirements.

Section 7: Benefits

7.1 General.
Each Participant will be entitled to receive for each Plan Year reimbursement of Qualifying Medical Expenses which are incurred during the Plan Year, which are not reimbursed by other medical plans, and which are not taken as a deduction on the Participant's income tax return, up to the dollar amount of coverage available to the Participant specified in the Benefit Description in Section 2 of this Summary Plan Description.

During the Plan Year, the Participant may be reimbursed for Qualifying Medical Expenses up to the full dollar amount of coverage less any prior reimbursements. If the Participant has elected family coverage, any Dependent is entitled to reimbursement for Qualifying Medical Expenses.

7.2 No Carry-Forward.
If a Participant (and/or his or her Dependents) incurs, during the Plan Year, aggregate expenses qualifying for reimbursement less than the dollar amount available for a Plan Year, any amount remaining as of the end of the Plan Year will not be carried forward for use in the next Plan Year and will be forfeited.

7.3 Forfeiture at Termination.
Participants are not entitled to reimbursement of any expenses that are incurred after termination of coverage under this Plan. If a Dependent terminates coverage during a Plan Year, the amount available will be re-adjusted to equal the amount that would have been available, minus any claims paid.

7.4 Benefits Limited to Expenses Incurred During Plan Year.
The benefits available under this Plan are only available to reimburse expenses that are incurred during the Plan Year and only during the period that the Participant or Dependent is covered. However, the Participant shall have until the end of the third month of the next Plan Year to submit claims for expenses incurred during the prior Plan Year. An expense is incurred during the Plan Year if the services giving rise to the expense are performed during the Plan Year. An expense shall not be deemed to be incurred during the Plan Year merely because a Participant receives a bill for the expense during the Plan Year or pays for the expense during the Plan Year.

7.5 Qualifying Medical Expenses.
Qualifying Medical Expenses shall include amounts that are considered "qualifying expenses" under the Health Plan, as described in the certificate of coverage, which are considered under the "in-network deductible" of the Health Plan.

7.6 Benefits for Mothers and Newborns.
The Newborns' and Mothers' Health Protection Act of 1996 requires group health plans, insurance companies, and HMO's that cover hospital stays following childbirth to provide coverage for a minimum period of time. In general, hospital coverage for the mother and newborn must be provided for a minimum of 48 hours following normal delivery, or 96 hours following a cesarean section. Group health plans may not restrict benefits for a hospital stay in connection with childbirth for the mother or newborn to less than 48 hours following delivery, and less than 96 hours following a caesarean section, unless the attending provider, after consultation with the mother, discharges the newborn earlier. A group health plan cannot require that a provider obtain authorization from the plan or third party administrator for a length of stay not in excess of these periods, but precertification may be required to reduce out-of-pockets costs or to use a certain provider or facility. Also, under federal law, issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

The Plan provides coverage in compliance with The Newborns' and Mothers' Health Protection Act.

7.7 Refund of Duplicate Reimbursements.
If a Participant receives a reimbursement under this Plan and reimbursement for the same expense is made under another plan, he will be required to refund the reimbursement to the Employer. The benefit amount available under this Plan, to the extent of any such refund, shall be reinstated for the Plan Year in which the reimbursement was originally made.

Section 8: Plan Administration

8.1 General.
The Plan Administrator shall have complete control of the administration of this Plan with all powers to enable it to carry out its duties in that respect, subject at all times to the limitations and conditions specified in or imposed by this Plan.

8.2 Duties and Policies of the Plan Administrator.
The Plan Administrator shall have the following duties, responsibilities and authority with respect to the administration of the Plan:
(a) To interpret the Plan and decide all questions of eligibility;
(b) To prescribe procedures to be followed by Participants in making elections;
(c) To prepare and distribute information explaining the Plan to Participants and Dependents;
(d) To receive from the Employer and from Participants such information as shall be necessary for the proper administration of the Plan;
(e) To furnish the Employer and Participants such annual reports with respect to the administration of the Plan as are reasonable and appropriate;
(f) To keep reports of claims and disbursements for claims under the Plan;
(g) To employ such persons, including, but not limited to, actuaries, accountants, and counsel, as it deems appropriate to perform such duties as may from time to time be required under ERISA and to render advice upon request with regard to any matters arising under the Plan;
(h) To modify elections under the Plan;
(I) To promulgate, as needed, election and claim forms to be used by Participants;
(j) To prepare and file any reports or returns with respect to the Plan required by applicable governmental agencies.
(k) To provide each Participant, with respect to each calendar year, a written statement showing the total reimbursements to the Participant under the Plan.
(1) To correct any reimbursement of expenses made in error.
(m) To take all other steps deemed necessary to properly administer the Plan in accordance with its terms and the requirements of applicable law.

Section 9: Plan Claims Procedures

9.1 Submission of Claims.
Participants must make claims for reimbursements under the Plan in writing following such procedures, including deadlines and documentation requirements, and using such forms as are prescribed by the Plan Administrator. All claims for reimbursement under the Plan must include an Explanation of Benefits from the Health Plan. The reimbursement application must include at least the following:

- The person or person on whose behalf the Qualifying Medical Expenses have been incurred;
- The nature and date of the expenses;
- The amount of the requested reimbursement; and

- A statement that such expenses have not otherwise been reimbursed.

Claims that are approved by the Plan Administrator will be paid within 30 days after receipt of the appropriate documentation, or as soon as possible thereafter. Participants may file claims for expenses incurred during a Plan Year up to three months following the end of the Plan Year.

Participants and/or Dependents whose coverage terminates must file all claims that were incurred by the Participant and his or her Dependents within three months after the termination.

9.2 Denials of Claims.
If the Plan Administrator receives an incomplete claim, it will provide to the Participant or Dependent who submitted the claim a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary. This notice will be provided within 5 days (or within 24 hours for urgent claims).

After receipt of all the information needed to review a claim, if any claim for benefits under the Plan is wholly or partially denied, the Plan Administrator will give notice in writing of such denial within a reasonable period of time. Notice of denial will be given no later than 30 days after the claim is filed for post-service claims, within 15 days for pre-service claims (and within 72 hours for urgent claims). Such notice shall set forth the following information:

(a) The specific reason or reasons for the denial;
(b) Specific reference to pertinent Plan provision, internal rule, guideline, protocol or similar criteria on which the denial is based; and
(c) An explanation that a full and fair review by a committee of the decision denying the claim may be requested by the claimant or his authorized representative by filing with the committee, within 180 days after such notice of denial has been received.

If the claimant requests a review of the claim denial, the claimant or his authorized representative may review pertinent documents and submit issues and comments in writing. All requests for review (or claim appeals) must be made in writing to the Plan Administrator within 180 days following receipt of the claim denial. The appeal will be reviewed by a committee or individual who was not involved in the initial denial. If the decision is based in whole or in part on medical judgment, the committee or individual will consult with a licensed physician or other medical professional as appropriate, who has expertise in the area of your claim. The claimant has the right to review all documents, records and other information that may be relevant to the appeal. The Plan Administrator will provide copies upon request.

The decision on review shall be made promptly, but not later than 30 days after receipt of the request for review, unless special circumstances require an extension of time for processing. The decision on review shall be made in writing and shall include specific reasons for the denial, including the name of any expert who was consulted during the appeal process, written in a manner calculated to be understood by the claimant, and shall include specific references to the pertinent Plan provisions on which the denial is based.

Section 10: Plan Funding

All benefits paid under this Plan shall be payable directly to applicable Participants and solely out of the general assets of the Employer. The Employer shall not establish a trust or fund for the contribution to or payment of benefits under this Plan, except as mandated by law. The Employer shall have no obligation to insure any of the benefits under this Plan.

Section 11: Amendments and Termination

The Employer shall have the sole right to alter, amend or terminate this Plan in whole or in part at any time it determines to be appropriate. The Board of Directors shall not amend, alter, or terminate this Plan retroactively, except to comply with applicable laws. No amendment or termination will retroactively diminish a Participant's right to obtain Plan benefits.

Section 12: Privacy and Security

The Plan will use a Participant's or Dependent's PHI, in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), only to make required disclosures or for purposes related to treatment, Payment for healthcare, and the Healthcare Operations of the Plan or to make any other disclosures that are required by Law. However, if a Participant or Dependent requests to see the information or provides a signed authorization, the Plan may use and disclose PHI as permitted and directed by the request or the authorization.

With respect to PHI, the Employer will:

- Not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by the individual that is the subject of the PHI;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual that is the subject of the PHI;
- Make PHI available to an individual in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available upon request an accounting of disclosures;
- Make available to the Secretary of the Department of Health and Human Services internal practices, books and records relating to the use and disclosure of PHI received from the Plan, for purposes of determining the Plan's compliance with HIPAA;
- Provide written notice or a substitute notice (if the last known contact address is insufficient) for each individual within 60 days following discovery of any breach of Unsecured PHI. The notice will include:
    - A brief description of what happened including the date of the breach and the date of discovery, if known;
    - A description of the types of unsecured PHI that were involved in the breach;
    - Any steps the individual should take to protect him/herself from potential harm resulting from the breach;
    - A brief description of what the Employer is doing to investigate the breach in accordance with HIPAA breach notification requirements;
    - Contact procedures for individuals to ask questions or learn additional information
- If a breach of Unsecured PHI involves more than 500 residents of a state, provide notice to local media outlets serving the state within 60 days of discovering the breach;
- If a breach of unsecured PHI involves more than 500 covered persons, provide notice to the DHHS not later than 60 days after the end of the calendar year in with the breach occurred;
- If feasible, return or destroy all PHI received from the Plan when such PHI is no longer needed for the purpose for which disclosure was made; and
- Use DHHS approved methods to secure and destroy PHI.

With respect to Electronic PHI, the Employer will, if PHI is or has been stored on the Employer's computer system:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or business associate to whom the Plan Sponsor provides electronic PHI agrees to comply with the HIPAA Security Requirements and to provide notice to the Plan of any Breach of Unsecured PHI, once the Breach is known to the agent or business associate or should reasonably have been known to the agent or business associate;
- Report to the Plan any security incident of which the Employer becomes aware; and
- Use methods to encrypt ePHI that are approved by the Department of Health and Human Services.

Only specified employees of the Employer may be given access to PHI, and they may use and disclose PHI only for plan administration functions (which includes both Payment and Health Care Operations) that the Employer performs for the Plan. If any of these persons do not comply with the HIPAA provisions of this Plan Document, the Employer will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Definitions.

"Breach" means the unauthorized acquisition, access, use, or disclosure of PHI in a manner not permitted by HIPAA privacy rules that compromises the security or privacy of the PHI.

"DHHS" means the federal Department of Health and Human Services.

"Electronic PHI" is health information about a plan participant that is in an electronic format. Health information includes information about the individual's past, present, or future physical or mental condition, the provision of health care to the individual, or the past, present, or future payment for the provision of health care to the individual.

"Health Care Operations" means activities of the Plan related to its health care functions, including quality assessment, case management, care coordination, reviewing competence of health care professionals, evaluating provider performance, health plan performance, cost management, resolution of grievances, or any other related activities.

"Payment" includes all activities regarding the provision of benefits under the Plan.

"Protected Health Information" or "PHI" shall mean any individually identifiable health information in electronic, oral or written form that pertains to the past, present or future mental or physical condition of an individual. Protected Health Information is limited to the information created or received by the Covered Entity or its business associate on behalf of the Health Plans. Protected Health Information also includes information for which there is a reasonable basis to believe that it can be used to identify an individual.

"Unsecured PHI" means PHI that is not secured through the use of a technology or methodology described in regulations to the HITECH Act or otherwise approved by the Secretary of the DHHS.

Section 13: Miscellaneous

13.1 No Employment Contract.

Nothing in this Plan shall be construed as a contract of employment between the Employer and any Employee, or as a guarantee of any Employee to be continued in the employment of the Employer, nor as a limitation on the right of the Employer to discharge any of its Employees with or without cause.

13.2 No Assignment.
A Participant's rights, interests or benefits under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of this Plan, and any such attempt shall be void.

13.3 Choice of Law.
This Plan shall be construed, administered and governed in all respects under applicable federal law, and to the extent not preempted by federal law, under the laws of the Commonwealth of Pennsylvania.

13.4 Severability.
If any provision of this Plan shall be held by court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

13.5 Gender, Singular and Plural References.
References in this Summary Plan Description to one gender shall include both genders, singular references shall include the plural, and plural references shall include the singular, unless the context clearly requires otherwise.

Section 14: Statement of ERISA Rights

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

Receive Information about the Plan and its Benefits

You are entitled to examine, without charge, at the Plan Administrator's office, and at other specified locations, all documents governing the Plan, including any insurance contracts, and if there are 100 or more participants, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You are entitled to obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), any updated summary plan description and, if there are 100 or more Participants, a copy of the latest annual report (Form 5500 Series). The Plan Administrator may make a reasonable charge for the copies.

If there are more than 100 Participants in the Plan, you are entitled to receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

During any plan year in which the Employer is subject to COBRA, you are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You are also entitled to review this summary plan description and the documents governing your COBRA continuation coverage rights.

You are entitled to reduction or elimination of any exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to any plan pre-existing condition exclusion which may be up to 12 months (or 18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently in the interest of you and other plan participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Participant's Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in federal court. The court shall decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.