LANCASTER GENERAL HEALTH

HEALTH CARE FSA
FLEXIBLE BENEFITS PLAN

PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2017

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INTRODUCTION

CREATION AND TITLE

Lancaster General Health hereby establishes this ***Plan*** under the terms and conditions set forth in this document. The ***Plan*** is to be known as the Lancaster General Health Flexible Benefits Plan (Health Care Flexible Spending Account).

EFFECTIVE DATE

The provisions of the ***Plan*** shall be effective as of January 1, 2017. The ***Plan*** was originally effective January 1, 2010.

PURPOSE

The purpose of the ***Plan*** is to allow participating employees to use pretax dollars to receive reimbursements for eligible out-of-pocket health care expenses ***incurred*** by them (and/or their ***spouse*** or eligible ***dependents***) and not otherwise covered by a health benefits program sponsored by the ***employer***. The ***employer*** intends that the ***Plan*** qualify as a nondiscriminatory flexible spending arrangement under Section 125 of the ***code*** (and application regulation) and a nondiscriminatory accident and health plan under Section 105(e) of the ***code***.

DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in ***bold and italics*** throughout the document.

Benefits Account

The administrative account established by the ***Plan Administrator*** under the ***Plan*** for each ***participant*** based on which ***health care reimbursement benefits*** shall be paid.

Claims Processor

CoreSource, Inc.

Code

The Internal Revenue Code of 1986, as amended from time to time.

Compensation

All the earned income, salary, wages, and other earnings paid by the ***employer*** to a ***participant***, including any amounts contributed by the ***employer*** pursuant to a salary reduction agreement, which are not includable in gross income under Sections 125, 402(g)(3), 402(h), 403(b) or 457(b) of the ***code***.

Dependent

An individual who is a dependent (within the meaning of Section 152(a) of the ***code***) of a ***participant*** in the ***Plan***.

Effective Date

January 1, 2017.

Eligible Employee

An ***employee*** who has met the eligibility requirements of the ***Plan*** as set forth herein.

Employee

An individual employed by the ***employer*** who is regularly scheduled to work at least the minimum number of hours per pay period required for participation.

Employer

Lancaster General Health or any successor by merger, consolidation, or purchase of substantially all of its assets and shall also include any of its affiliates, successors or assignors which adopt the ***Plan*** with the approval of Lancaster General Health.

Entry Date

For each ***employee***, the first day of the month coincident with or next following the day that the ***employee*** becomes eligible to participate in the ***Plan***.

Grace Period

For any ***Plan Year***, the period that begins immediately following the last day of the ***Plan Year*** and ends at the earlier of (i) the first date on which the ***benefits account*** balance for that ***Plan Year*** is reduced to zero or (ii) two and one-half months following the end of that ***Plan Year***. If no balance remains in a ***benefits account*** at the end of the ***Plan Year***, there shall be no ***grace period*** for that ***benefits account***.

Health Care Reimbursement Benefits

For any ***Plan Year***, the amount available to a ***participant*** as benefits under the ***Plan*** in the form of reimbursements of ***qualified expenses***.

Incurred or Incurred Date

For purposes of the ***Plan***, a medical expense is ***incurred*** on the date when the underlying services or products giving rise to the medical expense are performed or supplied and not on the date that the services or products are billed by the provider or paid by the ***participant***.

Over-the-Counter Drugs

Items which are legally procured without a prescription and which are generally accepted as falling within the category of medicine and drugs. ***Over-the-counter drugs*** do not include toiletries or similar preparations (such as toothpaste, shaving lotion, shaving cream, etc.), cosmetics (such as face creams, deodorants, hand lotions, etc. or any similar preparation used for ordinary cosmetic purposes), or dietary supplements that are merely beneficial to the general health of the individual (such as vitamins, etc.). The ***Plan Administrator*** has the sole discretionary authority to implement additional restrictions on the type or amount of items that qualify as ***over-the-counter drugs*** for purposes of this ***Plan***.

Participant

Any ***employee*** who has met the eligibility requirements of the ***Plan*** and has elected to participate in the ***Plan*** by completing an electronic enrollment process with the ***Plan Administrator***.

Participation Agreement

The agreement by an ***eligible employee*** that sets forth the ***employee's***: (i) election to participate in the ***Plan***, (ii) election of the amount of ***health care reimbursement benefits*** to be made available to the ***participant*** for a ***Plan Year*** as reimbursement for ***qualified expenses***, and (iii) authorization of the ***employer*** to reduce the ***employee's compensation*** while a ***participant*** during the ***Plan Year*** and to credit the ***participant's benefits account*** by such amount under the ***Plan***.

Plan

The Lancaster General Health Flexible Benefits Plan (Health Care Flexible Spending Account), as described herein.

Plan Administrator

The ***employer*** or such other person or committee as may be appointed by the ***employer*** to administer the ***Plan***.

Plan Sponsor

The ***Plan Sponsor*** is Lancaster General Health.

Plan Year

The twelve (12) consecutive month period beginning on January 1 and ending on December 31.

Privacy Rule

Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulation concerning privacy of individually identifiable health information.

Qualified Expenses

The medical expenses ***incurred*** during a ***Plan Year*** by a ***participant***, the ***participant's spouse***, or the ***participant's dependents***, and that qualify as expenses for "medical care" within the meaning of Section 213(d) of the ***code***. ***Qualified expenses*** do not include premium expenses for other health coverage, including (i) premiums paid for health coverage under a plan maintained by the employer of the ***employee's spouse*** or ***dependent*** or (ii) premiums for an individual health insurance policy. Expenses ***incurred*** for ***over-the-counter drugs*** cannot be considered ***qualified expenses*** unless such ***over-the-counter drugs*** are prescribed by a physician.

Required By Law

The same meaning as the term "required by law" as defined in 45 CFR 164.501, to the extent not preempted by ERISA or other Federal law.

Spouse

An individual who is legally married to a ***participant***, but shall not include an individual separated from a ***participant*** under a decree of legal separation.

SUMMARY PLAN DESCRIPTION

Name of Plan:

Lancaster General Health Flexible Benefits Plan (Health Care Flexible Spending Account)

Name, Address and Phone Number of Employer/Plan Sponsor:

Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604-3555
717-544-5511

Employer Identification Number:

23-2250941

Plan Number:

550

Group Number:

L0

Type of Plan:

Flexible spending arrangement under Section 125 of the ***code*** offering medical expense reimbursement accounts and cash. The ***Plan*** is also an accident and health plan under Section 105(e) of the ***code***.

Type of Administration:

Contract administration: The processing of claims for benefits under the terms of the ***Plan*** is provided through a company contracted by the ***employer*** and shall herein be referred to as the ***claims processor***.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent for Service of Legal Process:

Vice President – Human Resources
Lancaster General Health
555 North Duke Street
P.O. Box 3555
Lancaster, PA 17604-3555
717-544-5511

Legal process may be served upon the ***Plan Administrator***.

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the ***Plan*** and the events and circumstances upon which participation terminates, refer to the *Participation* section of the ***Plan***.

Source of Plan Contributions:

Contributions for ***Plan*** expenses are obtained from the ***employer*** in accordance with elections of ***employees*** pursuant to annual electronic enrollment. The ***employer*** evaluates the costs of the ***Plan*** based on participation and determines the amount to be contributed by the ***employer***.

Funding Method:

The ***employer*** pays ***Plan*** administration expenses directly from general assets. ***Participants***, ***spouses*** and ***dependents*** shall have no legal or equitable rights, claims or interests in any specific property or assets of the ***employer***. No assets of the ***employer*** shall be held in any way as collateral security or otherwise dedicated for payment of benefits under this ***Plan***. Any and all of the ***employer's*** assets shall be, and remain, the general unpledged, unrestricted assets of the ***employer***. The ***employer's*** obligation under the ***Plan*** shall be that of an unfunded and unsecured promise of the ***employer*** to meet the ***Plan's*** obligations. No ***Plan*** provision concerning allocation or accounting of credits shall be construed as requiring any separate funding.

Ending Date of Plan Year:

December 31

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, *Claims Procedure*.

The designated ***claims processor*** is:

CoreSource, Inc.
1811 Rahling Road, Suite 100
Little Rock, Arkansas 72223

Statement of ERISA Rights:

Participants in the ***Plan*** are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all ***participants*** shall be entitled to:

1. Examine, without charge, at the ***Plan Administrator's*** office and at other specified locations, such as worksites and union halls, all documents governing the ***Plan***, including any collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the ***Plan*** with the U.S. Department of Labor.

2. Obtain, upon written request to the ***Plan Administrator***, copies of documents governing the operation of the ***Plan***, including any collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The ***Plan Administrator*** may make a reasonable charge for the copies.

3. 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 (SAR).

4. Continue plan participation for the ***participant***, ***spouse*** or ***dependent*** if there is a loss of coverage under the ***Plan*** as the result of a qualifying event. The ***participant***, ***spouse*** or ***dependent*** may have to pay for such coverage. Review this summary plan description and the documents governing the ***Plan***, as it relates to governing COBRA continuation coverage rights.

In addition to creating rights for ***Plan participants***, ERISA imposes obligations upon the people who are responsible for the operation of the ***Plan***. The people who operate the ***Plan***, called "fiduciaries" of the ***Plan***, have a duty to do so prudently and in the interest of all ***Plan participants***.

No one, including the ***employer*** or any other person, may fire an ***employee*** or discriminate against an ***employee*** to prevent the ***employee*** from obtaining any benefit under the ***Plan*** or exercising their rights under ERISA.

If claims for benefits under the ***Plan*** are denied, in whole or in part, the ***participant*** must receive a written explanation of the reason for the denial. The ***participant*** has the right to have the ***Plan*** review and reconsider the claim.

Under ERISA, there are steps ***participants*** can take to enforce their rights. For instance, if material is requested from the ***Plan*** and the material is not received within thirty (30) days, the ***participant*** may file suit in a federal court. In such case, the court may require the ***Plan Administrator*** to provide the materials and pay the ***participant*** up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the ***Plan Administrator***. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the ***participant*** may file suit in a state or federal court.

If it should happen that ***Plan*** fiduciaries misuse the ***Plan's*** money, or if ***participants*** are discriminated against for asserting their rights, ***participants*** may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the ***participant*** is successful, the court may order the person who is sued to pay these costs and fees. If the ***participant*** loses, the court may order the ***participant*** to pay the costs and fees; for example, if it finds the ***participant's*** claim frivolous.

Participants should contact the ***Plan Administrator*** for questions about the ***Plan***. For questions about this statement or about rights under ERISA, ***participants*** should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. ***Participants*** may also obtain certain publications about their rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PARTICIPATION

ELIGIBILITY

All regular full-time and part-time ***employees***, 0.5 FTE or greater, shall be eligible to enroll for coverage under this ***Plan***.

For the following Management Levels, eligible ***employees***, as described in the *Eligibility* section, are enrolled under the ***Plan*** immediately upon the date of hire, provided the ***employee*** has enrolled for coverage as described in *Commencement of Participation*.

- Assistant Dean College
- Associate Vice President College
- Chair
- Chief
- Chief Executive Officer
- Dean College
- Director
- Director/Physician
- Director AIP
- Director College
- Executive Vice President
- Manager College
- Managing Physician
- President College
- Senior Director
- Senior Vice President
- Staff Physician
- Staff Resident
- Supervising Physician
- Vice President
- Vice President College
- Vice President Physician
- The following Advanced Practice Providers
    - Clinical Nurse Specialist
    - CRNA
    - Nurse Practitioner
    - Nurse Practitioner-Specialty

For Management Levels not noted above, eligible ***employees***, as described in the *Employee Eligibility* section, are enrolled under the ***Plan*** upon completion of thirty (30) days of active service, provided ***employee*** has enrolled for coverage as described in *Commencement of Participation*.

COMMENCEMENT OF PARTICIPATION

An ***eligible employee*** shall become a ***participant*** in the ***Plan*** after providing the ***Plan Administrator*** with a completed electronic enrollment election, setting forth the benefits to be made available to the ***eligible employee*** for the ***Plan Year***, immediately following; or remaining portion, of the ***Plan Year***. As part of the ***participation agreement***, the ***participant*** shall authorize the ***employer*** to reduce the ***participant's compensation*** for the ***Plan Year*** (or the remaining portion thereof) by an amount up to the IRS limit that the ***participant*** elects to have credited to his or her ***benefits account*** under the ***Plan***. The ***participant*** must, before the end of the first ***Plan Year*** of participation

and, before the end of each subsequent ***Plan Year***, provide the ***Plan Administrator*** with a new electronic enrollment election. Each new electronic enrollment election shall specify the amount of ***health care reimbursement benefits*** to be made available to the ***participant*** for the ***Plan Year*** immediately following; or remaining portion, of the ***Plan Year***.

TERM OF PARTICIPATION

Each ***participant*** shall be a ***participant*** in the ***Plan*** for the entire ***Plan Year*** or the portion of the ***Plan Year*** remaining after the ***participant's entry date***, if later than the first day of the ***Plan Year***. A ***participant*** shall cease to be a ***participant*** in the ***Plan*** on the earliest of:

1. the date the ***participant*** dies, resigns or terminates employment with the ***employer***, subject to the provisions in the section below entitled *Participation By Rehired Employees*;

2. the date the ***participant*** fails to make required contributions under the ***Plan***;

3. the date the ***participant*** ceases to be an ***employee*** or otherwise becomes no longer eligible to participate under the terms of the ***Plan***; or

4. the date the ***Plan*** terminates.

PARTICIPATION BY REHIRED EMPLOYEES

Each ***participant*** in the ***Plan*** who separates from service with the ***employer*** shall suspend participation under this ***Plan*** for the period from the date of termination to the last day of the ***Plan Year*** in which termination occurred. During such period of suspension, any contributions pursuant to a ***participation agreement*** shall cease. Participation in the ***Plan*** shall terminate on the first day of the next ***Plan Year***, provided the terminated ***employee*** has not been rehired by the ***employer*** on such date. If a terminated ***employee*** should later be rehired by the ***employer*** in the same ***Plan Year*** as the ***Plan Year*** in which he or she separated from service, such ***employee*** may elect to resume participation in the ***Plan*** under the terms of the ***participation agreement*** in effect on the date of termination of employment.

BENEFITS

PROVISION OF BENEFITS

Benefits under the ***Plan*** shall take the form of reimbursement of ***qualified expenses incurred*** by a ***participant***, the ***participant's spouse*** and/or ***dependents*** during the ***Plan Year***. Benefits under the ***Plan*** shall be available solely for ***qualified expenses incurred*** during the ***participant's*** participation in the ***Plan***.

AMOUNT OF REIMBURSEMENT

A ***participant*** shall be entitled to benefits under the ***Plan*** for a ***Plan Year*** in an amount that does not exceed the ***participant's health care reimbursement benefits***. The amount of a ***participant's health care reimbursement benefits*** shall be uniformly available during the ***Plan Year***.

CHANGE IN PARTICIPATION ELECTION

A ***participant*** may not change the amount of ***health care reimbursement benefits*** to be made available for a ***Plan Year*** during that ***Plan Year***, except in accordance with the rules for changes in elections as set forth in the section below entitled *Election Changes*.

FAMILY AND MEDICAL LEAVE ACT

For any leave, and solely to the extent the provisions of the Family and Medical Leave Act of 1993 ("FMLA") apply and such leave qualifies as a FMLA leave, the ***participant*** may remain a ***participant*** and shall be entitled to receive the same benefits as before the start of the FMLA leave, subject to the continued payment of any required contributions under the ***Plan***. Solely to the extent required under FMLA, a ***participant*** whose ***health care reimbursement benefits*** have been suspended or terminated while on an FMLA leave (whether due to revocation, nonpayment of premiums or otherwise) may have such ***health care reimbursement benefits*** reinstated on return from the FMLA leave on the same terms as prior to taking the FMLA leave, subject to any changes in benefit levels that may have taken place during the period of FMLA leave.

NONDISCRIMINATORY BENEFITS

The ***Plan***, in accordance with applicable provisions of the ***code***, is intended to not discriminate in favor of highly compensated individuals as to eligibility to participate, contributions and/or benefits. The ***Plan Administrator*** may take such actions as it deems appropriate or necessary to ensure that the ***Plan*** is not deemed a discriminatory plan under applicable provisions of the ***code***, which actions may include excluding certain highly compensated individuals from participation in the ***Plan***.

PAYMENT

PARTICIPANTS' ACCOUNTS

The ***Plan Administrator*** shall establish a separate ***benefits account*** for each ***participant*** in the ***Plan***. The ***Plan Administrator*** shall credit a ***participant's benefits account*** with the amount of ***health care reimbursement benefits*** to be made available to the ***participant*** pursuant to the ***participant's participation agreement***. The ***Plan Administrator*** shall charge a ***participant's benefits account*** in the amount of any reimbursement made to the ***participant***.

PAYMENT OF BENEFITS

Reimbursement shall only be made under the ***Plan*** on the basis of ***qualified expenses incurred*** by the ***participant***, the ***participant's spouse*** or the ***participant's dependents***, as presented to the ***Plan Administrator*** on a written form specified by the ***Plan Administrator*** and as evidenced by a written statement from a third party. It shall be the duty of the ***Plan Administrator*** to determine whether or not an expense constitutes a ***qualified expense***. To make the determination that a ***qualified expense*** subject to reimbursement has been ***incurred***, the ***Plan Administrator*** may require proper evidence of any or all of the following:

1. the name of the person or persons for whom the expenses have been ***incurred***;

2. the nature of the expenses ***incurred***;

3. the ***incurred date***;

4. the amount of the requested reimbursement; and/or

5. that the expenses have not been otherwise paid or reimbursed from another source.

If the ***Plan Administrator*** determines that an expense is a ***qualified expense*** subject to reimbursement, the ***Plan Administrator*** shall reimburse the ***participant*** for the ***qualified expense*** within a reasonable time. The ***Plan Administrator*** shall be the sole arbiter of what constitutes a ***qualified expense*** subject to reimbursement under the ***Plan***.

However, if a ***qualified expense*** was ***incurred*** directly through an automatic debit card system, the ***participant*** shall not be required to separately file a claim for reimbursement or supporting evidence for such expense unless requested by the ***Plan Administrator*** (or its designee) in order to verify that the reimbursement was properly provided.

In the event of the death of the ***participant*** prior to the payment of any claims, payment shall be made in the following priority:

1. Executor of the Estate of the deceased ***participant***;

2. ***Spouse***;

3. Family member held responsible for payment of deceased's medical bills;

4. ***Spouse*** or ***dependent*** with COBRA continuation rights.

GRACE PERIOD

A ***grace period*** of up to two and one-half months is applied to a ***participant's health care reimbursement account*** at the end of a ***Plan Year***, in the event any balance is remaining. Claims for benefits (*see Claims Procedure* section) will be processed as follows - (i) reimbursements for ***qualified expenses incurred*** during the prior ***Plan Year*** and not previously reimbursed shall be made from the ***participant's*** prior ***Plan Year's account*** until the balance is exhausted or forfeited, and (ii) reimbursements for ***qualified expenses incurred*** during the ***grace period*** shall be made first from the ***participant's*** prior ***Plan Year's account*** until the balance is exhausted or forfeited and then from the current ***Plan Year's account*** to the extent necessary.

FORFEITURE OF BENEFITS

A ***participant*** forfeits any balance reflected in their ***health care reimbursement account*** for a ***Plan Year***, to the extent a claim for ***qualified expenses incurred***, is not provided to the ***Plan Administrator*** within ninety (90) days after the earlier of: (i) the last day of the ***Plan Year's grace period*** or (ii) the last day of participation in the ***Plan***. Upon such forfeiture, the ***participant's health care reimbursement account*** for that ***Plan Year*** shall be reduced to zero. Forfeited amounts may also be applied towards the cost of administering the ***Plan***. In no event shall any forfeitures be subject to the claim of any current or former ***participant***, ***spouse*** or ***dependent*** or any of their successors or assigns. In addition, any benefit payments for ***qualified expenses incurred*** during the ***Plan Year*** or ***grace period*** that are unclaimed (uncashed benefit checks) by the end of the sixth month following the end of the ***grace period*** shall be forfeited and applied as described in this section.

ELECTION CHANGES

No ***participant*** in the ***Plan*** shall be allowed to alter or discontinue the ***participant's*** elected benefits under the ***Plan*** during a ***Plan Year*** except as follows:

1. An election change that is on account of and corresponds with any of the following status change that affects eligibility for coverage under the ***Plan***:

    a. Change in ***employee's*** legal marital status;
    b. Change in number of ***dependents***;
    c. Termination or commencement of employment by the ***employee***, ***spouse*** or ***dependent***;
    d. Change in employment status for the ***employee***, ***spouse*** or ***dependent*** that results in change of eligibility under the ***Plan*** or other employee benefit plan of the employer of the ***employee***, ***spouse*** or ***dependent***;
    e. An event that causes an individual to satisfy (or cease to satisfy) ***dependent*** eligibility requirements on account of age, student status or any similar circumstance; or
    f. Change in residence or worksite of the ***employee***, ***spouse*** or ***dependent***.

2. An election change in connection with taking or returning from a leave of absence under the Family and Medical Leave Act of 1993 (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA).

3. An election change that is pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody that requires coverage for an ***employee's*** child.

4. An election change to cancel, reduce, commence, or increase coverage under the ***Plan*** to correspond with enrollment in, or loss of coverage under, Medicare, Medicaid or a state child health insurance program (CHIP).

5. Upon a COBRA qualifying event, an election to increase payments under the ***Plan*** to pay for continuation coverage.

A mid-year election change as permitted above can only be effectuated by the ***participant*** filing a new ***participation agreement***, which will serve to revoke the ***participant's*** previous ***participation agreement*** or electronic enrollment election. The new ***participation agreement***, if determined by the ***Plan Administrator*** to be timely submitted and consistent with other requirements of this ***Plan***, shall only be effective prospectively and after the effective date of the new ***participation agreement***.

CLAIMS PROCEDURE

GENERAL

No benefit shall be paid hereunder unless the ***claims processor*** has received from the ***participant***, ***spouse*** or ***dependent*** (as applicable) (or authorized representative) a written claim for benefits in accordance with the provisions of this section.

FILING A CLAIM

Claims for benefits under this ***Plan*** must be submitted to the ***claims processor*** at the following address:

CoreSource, Inc.
P. O. Box 8215
Little Rock, Arkansas 72221-8215

All claims for benefits under this ***Plan*** must be submitted on an approved form and include such evidence as the ***claims processor*** may deem reasonably necessary to administer the claim, including such evidence that substantiates the nature, the amount, and timeliness of any expenses that may be reimbursed.

Claims for benefits under this ***Plan*** must be received by the ***claims processor*** within ninety (90) days of the close of the ***Plan Year*** in which the relevant expense was ***incurred***. Notwithstanding the foregoing, for any ***health care reimbursement account*** that has a remaining balance at the end of the ***Plan Year***, ***qualified expenses incurred*** during such ***Plan Year*** or during the ***grace period*** (and not previously reimbursed) shall be eligible for reimbursement from such remaining balance if a properly completed claim for benefits is received by the ***claims processor*** within forty-five (45) days of the end of the ***grace period***. All claims that are not timely received shall be denied.

However, if a ***qualified expense*** was ***incurred*** directly through an automatic debit card system, the ***participant*** shall not be required to separately file a claim for reimbursement or supporting evidence for such expense, unless requested by the ***Plan Administrator*** (or its designee) in order to verify that the reimbursement was properly provided.

NOTICE OF AUTHORIZED REPRESENTATIVE

A ***participant***, ***spouse*** or ***dependent*** may provide the ***claims processor*** with a written authorization that (i) designates and authorizes another person or entity to act on his or her behalf and (ii) consents to the communication of information related to him or her to the authorized representative with respect to a claim for benefits or an appeal of a denied claim. Authorization forms may be obtained from the Human Resources/Benefits Department.

BENEFIT DETERMINATION

After receipt by the ***claims processor*** of a completed claim for benefits under this ***Plan***, the ***claims processor*** shall complete its determination of the claim within thirty (30) days unless an extension is necessary due to circumstances beyond the ***Plan's*** control. If additional information is needed for determination of the claim, the ***claims processor*** shall provide the claimant (or authorized representative) with a notice detailing the information needed. The notice shall be provided within thirty (30) days of receipt of the completed claim and shall state the date as of which the ***Plan*** expects to make a decision. The claimant shall have forty-five (45) days to provide the information requested, and the ***claims processor*** shall complete its determination of the claim within fifteen (15) days of receipt of the requested information. Failure to respond in a timely and complete manner shall result in the denial of benefit payment.

If a claim for benefits under this ***Plan*** is denied, the ***claims processor*** shall provide the claimant (or authorized representative) with a written notice of benefit denial within the time-frame for determination as described in this section.

APPEALING A DENIED CLAIM

If a claim for benefits under this ***Plan*** is denied, the claimant (or authorized representative) may request a review of the denied claim by making a written request to the ***claims processor*** within one hundred eighty (180) days from receipt of the notification of the denial and stating the reasons the claimant feels the claim should not have been denied. The ***claims processor*** shall provide the claimant (or authorized representative) with a written notice of the appeal decision within sixty (60) days of receipt of a written request for the appeal.

The following describes the review process and rights of the claimant:

1. The claimant has the right to submit documents, information and comments;
2. The claimant has the right to receive and access, free of charge, information relevant to the claim for benefits;
3. The review must take into account all information submitted by the claimant, even if it was not considered in the initial benefit determination;
4. The review shall not afford deference to the original denial; and
5. The reviewer shall not be the individual who originally denied the claim, nor a subordinate to the individual who originally denied the claim.

NAMED FIDUCIARY FOR CLAIM APPEALS

The ***claims processor*** shall be the "named fiduciary" for purposes of reviewing a claim for benefits upon appeal.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this ***Plan*** includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This continuation of coverage may be commonly referred to as "COBRA coverage" or "continuation coverage."

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this ***Plan*** or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date coverage would otherwise terminate:

1. Death of the ***employee***.
2. The ***employee's*** termination of employment (other than termination for gross misconduct) or reduction in work hours to less than the minimum required for coverage under the ***Plan***.
3. Divorce or legal separation from the ***employee***.
4. The ***employee's*** entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this ***Plan***.
5. A ***dependent*** child no longer meets the eligibility requirements of the ***Plan***.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the ***employee*** informs the ***employer*** that he or she will not be returning to work.
7. The call-up of an ***employee*** reservist to active duty.

For purposes of this *Continuation of Coverage* section, the term "***dependent***" will be used to refer to the ***employee's spouse*** and/or ***dependents***. Notwithstanding any provision in this document to the contrary, none of the above events shall be considered a qualifying event unless, as of the date of such event, the maximum amount of benefit that may become available to the ***employee*** or the ***dependent*** (as applicable) during the remainder of the ***Plan Year*** pursuant to this *Continuation of Coverage* section exceeds the maximum amount that the ***Plan*** is permitted to require to be paid for continuation coverage for the remainder of the ***Plan Year***.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a ***spouse*** being divorced or legally separated from an enrolled ***employee***, or a child's loss of ***dependent*** status, the ***employee*** or ***dependent*** must submit a completed Qualifying Event Notification form to the ***Plan Administrator*** (or its designee) within sixty (60) days of the latest of:

    a. The date of the event;
    b. The date on which coverage under this ***Plan*** is or would be lost as a result of that event; or
    c. The date on which the ***employee*** or ***dependent*** is furnished with a copy of this Plan Document and Summary Plan Description.

    A copy of the Qualifying Event Notification form is available from the ***Plan Administrator*** (or its designee). In addition, the ***employee*** or ***dependent*** may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the ***Plan Administrator*** (or its designee) will notify the ***employee*** or ***dependent*** of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation coverage results from any qualifying event under this ***Plan*** other than the ones described in Paragraph 1 above, the ***employer*** must notify the ***Plan Administrator*** (or its designee) not later than thirty (30) days after the date on which the ***employee*** or ***dependent*** loses coverage under the ***Plan*** due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the ***Plan Administrator*** (or its designee) will furnish the Election Notice to the ***employee*** or ***dependent***.

3. In the event it is determined that an individual seeking continuation coverage (or extension of continuation coverage) is not entitled to such coverage, the ***Plan Administrator*** (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible ***employee*** or ***dependent*** has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the ***Plan*** on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the ***employee*** or ***dependent*** chooses to have continuation coverage, he must advise the ***Plan Administrator*** (or its designee) of this choice by returning to the ***Plan Administrator*** (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the ***Plan Administrator*** (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

   a. The date coverage under the ***Plan*** would otherwise end; or
   b. The date the person receives the Election Notice from the ***Plan Administrator*** (or its designee).

5. Within forty-five (45) days after the date the person notifies the ***Plan Administrator*** (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance, on the first day each month.

COST OF COVERAGE

1. The ***Plan*** requires that covered persons pay the entire cost of their continuation coverage. Except for the initial payment (see above), payments must be remitted to the ***Plan Administrator*** (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an ***employee*** or as a ***spouse***, the cost of coverage is the amount applicable to an ***employee*** if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an ***employee***.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for ***dependents*** acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the ***Plan***.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A ***spouse*** or ***dependent*** child newly acquired during continuation coverage is eligible to be enrolled as a ***dependent***. The standard enrollment provision of the ***Plan*** applies to enrollees during continuation coverage. A ***dependent*** acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with an enrolled ***employee*** during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. The last day of the ***Plan Year*** in which the qualifying event occurred.

2. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the ***Plan Administrator*** (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this ***Plan*** or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

3. The date coverage under this ***Plan*** ends and the ***employer*** offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

4. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

5. The date the covered person first becomes covered under any other employer's group health plan after the original date of the covered person's election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the covered person's pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this ***Plan*** must, at minimum, contain sufficient information so that the ***Plan Administrator*** (or its designee) is able to determine from such notice the ***employee*** and ***dependent(s)*** (if any), the qualifying event, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this ***Plan***, any notice required to be provided by any individual who is either the ***employee*** or a ***dependent*** with respect to the qualifying event may be provided by a representative acting on behalf of the ***employee*** or the ***dependent***, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:

    a. A single notice addressed to both the ***employee*** and the ***spouse*** will be sufficient as to both individuals if, on the basis of the most recent information available to the ***Plan***, the ***spouse*** resides at the same location as the ***employee***; and
    b. A single notice addressed to the ***employee*** or the ***spouse*** will be sufficient as to each ***dependent*** child of the ***employee*** if, on the basis of the most recent information available to the ***Plan***, the ***dependent*** child resides at the same location as the individual to whom such notice is provided.

MILITARY MOBILIZATION

If an ***employee*** is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the ***employee*** and ***employee's dependent*** may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the ***employee*** and ***employee's dependent*** may not be required to pay more than the ***employee's*** share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer, then the ***Plan Administrator*** (or its designee) may require the ***employee*** and ***employee's dependent*** to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the ***employee*** fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty and subject to premium contribution requirement and other applicable requirements as described in the *Participation* section, coverage for the ***employee*** and the ***employee's dependent*** will be reinstated without pre-existing conditions exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

PLAN CONTACT INFORMATION

Questions concerning this ***Plan***, including any available continuation coverage, may be directed to the ***Plan Administrator*** (or its designee).

ADDRESS CHANGES

In order to help ensure the appropriate protection of rights and benefits under this ***Plan***, ***participants*** should keep the ***Plan Administrator*** (or its designee) informed of any changes to their current addresses.

HIPAA PRIVACY

The following provisions are intended to comply with applicable ***Plan*** amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DISCLOSURE BY PLAN TO PLAN SPONSOR

The ***Plan*** may take the following actions only upon receipt of a plan amendment certification:

1. Disclose protected health information to the ***Plan Sponsor***.

2. Provide for or permit the disclosure of protected health information to the ***Plan Sponsor*** by a health insurance issuer or HMO with respect to the ***Plan***.

USE AND DISCLOSURE BY PLAN SPONSOR

The ***Plan Sponsor*** may use or disclose protected health information received from the ***Plan*** to the extent not inconsistent with the provisions of this *HIPAA Privacy* section or the ***privacy rule***.

OBLIGATIONS OF PLAN SPONSOR

The ***Plan Sponsor*** shall have the following obligations:

1. Ensure that:

    a. Any agents (including a subcontractor) to whom it provides protected health information received from the ***Plan*** agree to the same restrictions and conditions that apply to the ***Plan Sponsor*** with respect to such information; and

    b. Adequate separation between the ***Plan*** and the ***Plan Sponsor*** is established in compliance with the requirement in 45 C.F.R. 164.504(f)(2)(iii).

2. Not use or further disclose protected health information received from the ***Plan***, other than as permitted or required by the ***Plan*** documents or as ***required by law***.

3. Not use or disclose protected health information received from the ***Plan***:

    a. For employment-related actions and decisions; or

    b. In connection with any other benefit or employee benefit plan of the ***Plan Sponsor***.

4. Report to the ***Plan*** any use or disclosure of the protected health information received from the ***Plan*** that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the ***Plan***, as and to the extent required by the ***privacy rule***:

    a. For access to the individual;

    b. For amendment and incorporate any amendments to protected health information received from the ***Plan***; and

    c. To provide an accounting of disclosures.

6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the ***Plan*** available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the ***Plan*** with the ***privacy rule***.

7. Return or destroy all protected health information received from the ***Plan*** that the ***Plan Sponsor*** still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the ***Plan*** was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information received from the ***Plan*** only to those individuals, under the control of the ***Plan Sponsor*** who perform administrative functions for the ***Plan***; (*i.e.*, eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information received from the ***Plan*** for any reason other than for ***Plan*** administrative functions nor to release protected health information received from the ***Plan*** to an unauthorized individual.

9. Provide protected health information received from the ***Plan*** only to those entities required to receive the information in order to maintain the ***Plan***.

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the ***Plan Sponsor*** on behalf of the ***Plan***. Specifically, such safeguarding entails an obligation to:

    a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the ***Plan Sponsor*** creates, receives, maintains, or transmits on behalf of the ***Plan***;
    b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
    c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
    d. Report to the ***Plan*** any security incident of which it becomes aware.

EXCEPTIONS

Notwithstanding any other provision of this *HIPAA Privacy* section, the ***Plan*** (or a health insurance issuer or HMO with respect to the ***Plan***) may:

1. Disclose summary health information to the ***Plan Sponsor***:

    a. If the ***Plan Sponsor*** requests it for the purpose of:

        (i.) Obtaining premium bids from health plans for providing health insurance coverage under the ***Plan***; or

        (ii.) Modifying, amending, or terminating the ***Plan***;

2. Disclose to the ***Plan Sponsor*** information on whether the individual is participating in the ***Plan***, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the ***Plan***;

3. Use or disclose protected health information:

    a. With (and consistent with) a valid authorization obtained in accordance with the ***privacy rule***;
    b. To carry out treatment, payment, or health care operations in accordance with the ***privacy rule***; or
    c. As otherwise permitted or required by the ***privacy rule***.

PLAN ADMINISTRATION

PLAN ADMINISTRATOR

The ***Plan Administrator*** shall be responsible for the administration of the ***Plan***.

PLAN ADMINISTRATOR'S DUTIES

In addition to any rights, duties or powers specified throughout the ***Plan***, the ***Plan Administrator*** shall have the following rights, duties and powers:

1. to interpret the ***Plan***, to determine the amount, manner and time for payment of any benefits under the ***Plan***, and to construe or remedy any ambiguities, inconsistencies or omissions under the ***Plan***;

2. to adopt and apply any rules or procedures to ensure the orderly and efficient administration of the ***Plan***;

3. to determine the rights of any ***participant***, ***spouse*** or ***dependent*** or beneficiary to benefits under the ***Plan***;

4. to develop appellate and review procedures for any ***participant***, ***spouse***, ***dependent*** or designated beneficiary with regard to denied benefits under the ***Plan***;

5. to provide the ***employer*** with such tax or other information it may require in connection with the ***Plan***;

6. to employ any agents, attorneys, accountants or other parties (who may also be employed by the ***employer***) and to allocate or delegate to them such powers or duties as are necessary to assist in the proper and efficient administration of the ***Plan***, provided that such allocation or delegation and the acceptance thereof are in writing;

7. to report to the ***employer***, or any party designated by the ***employer***, after the end of each ***Plan Year***, regarding the administration of the ***Plan***; and to report any significant problems as to the administration of the ***Plan*** and to make recommendations for modifications as to procedures and benefits, or any other change which might ensure the efficient administration of the ***Plan***.

However, nothing in this section is meant to confer upon the ***Plan Administrator*** any powers to amend the ***Plan*** or change any material administrative procedure or adopt any other material procedure involving the ***Plan*** without the express written approval of the ***employer***. Notwithstanding the preceding sentence, the ***Plan Administrator*** is empowered to take any actions he sees fit to assure that the ***Plan*** complies with the nondiscrimination requirements of Sections 105 and/or 125 of the ***code***.

INFORMATION TO BE PROVIDED TO PLAN ADMINISTRATOR

The ***employer***, or any of its agents, shall provide to the ***Plan Administrator*** any employment records of any ***employee*** eligible to participate under the ***Plan***. Such records shall include, but will not be limited to, any information regarding period of employment, leaves of absence, salary history, termination of employment, or any other information the ***Plan Administrator*** may need for the proper administration of the ***Plan***. Any ***participant***, ***spouse*** or ***dependent*** entitled to benefits under the ***Plan*** shall furnish to the ***Plan Administrator*** his correct post office address, his date of birth, the names, correct addresses and dates of birth of any designated beneficiaries, with proper proof thereof, or any other data the ***Plan Administrator*** might reasonably request to ensure the proper and efficient administration of the ***Plan***.

DECISION OF PLAN ADMINISTRATOR FINAL

Subject to applicable State or Federal law and the provisions of this ***Plan***, any interpretation of any provision of this ***Plan*** made in good faith by the ***Plan Administrator*** as to any rights or benefits of a ***participant***, ***spouse*** or ***dependent*** under this ***Plan*** is final and shall be binding upon the parties. Any misstatement or other mistake of fact shall be corrected as soon as reasonably possible upon notification to the ***Plan Administrator*** and any adjustment or correction attributable to such misstatement or mistake of fact shall be made by the ***Plan Administrator*** as he considers equitable and practicable.

RULES TO APPLY UNIFORMLY

The ***Plan Administrator*** shall perform his duties in a reasonable manner and on a nondiscriminatory basis and shall apply uniform rules to all ***participants*** similarly situated under the ***Plan***.

GENERAL PROVISIONS

EMPLOYER OBLIGATION

The ***employer***, upon adopting the ***Plan***, shall have the obligation to pay, or to have paid on its behalf, the contributions required for payment of benefits under the ***Plan*** in respect of its employees.

AMENDMENT AND TERMINATION

Lancaster General Health may amend, modify, or terminate this ***Plan*** at any time, to any extent, and for any reason, all in its sole discretion. Any amendment may be made effective retroactively to the extent not prohibited by ERISA and the Internal Revenue Code. Coverage upon termination shall be governed by the terms of the ***Plan***.

NONASSIGNABILITY

Any benefits under this ***Plan*** shall be nonassignable and for the exclusive benefit of ***participants***, ***spouses***, and ***dependents***. No benefit shall be voluntarily or involuntarily assigned, sold or transferred.

MEDICAL CHILD SUPPORT ORDERS

To the extent applicable, the ***Plan Administrator*** shall adhere to the terms of any judgment, decree or court order (including a court's approval of a domestic relations settlement agreement) which

1. relates to the provision of child support related to health benefits for a child of a ***participant*** of a group health plan;
2. is made pursuant to a state domestic relations law; and
3. which creates or recognizes the right of an alternate recipient to, or assigns to an alternate recipient the right to receive benefits under the group health plan under which a ***participant*** or other beneficiary is entitled to receive benefits.

The ***Plan Administrator*** shall promptly notify the ***participant*** and each alternate recipient named in the medical child support order of the ***Plan's*** procedures for determining the qualified status of the medical child support orders. Within a reasonable period after receipt of a medical child support order, the ***Plan Administrator*** shall determine whether such order is a Qualified Medical Child Support Order (QMCSO) as defined in Section 609 of ERISA or National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998 and shall notify the ***participant*** and each alternate recipient of such determination. If the ***participant*** or any affected alternate payee objects to the determination of the ***Plan Administrator***, the disagreeing party shall be treated as a claimant and the claims procedure of the ***Plan*** shall be followed. The ***Plan Administrator*** may bring an action for a declaratory judgment in a court of competent jurisdiction to determine the proper recipient of the benefits to be paid by the ***Plan***.

Any such QMCSO or NMSN must clearly specify the name and last known mailing address of the ***participant***, name and address of each alternate recipient covered by the order, a description of the coverage to be provided by the group health plan or the manner in which such coverage is to be determined, the period of coverage that must be provided, and each plan to which such order applies.

Any such QMCSO or NMSN shall not require the ***Plan*** to provide any type or form of benefits, or any option, that it is not already offering except as necessary to meet the requirements of a state medical child support law described in Section 1908 of the Social Security Act as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1983 (OBRA '93).

Upon determination that a medical child support order is a QMCSO or NMSN, the ***Plan*** must recognize the QMCSO or NMSN by providing benefits for the ***participant's*** child in accordance with such order.

NOT AN EMPLOYMENT CONTRACT

By creating this ***Plan*** and providing benefits under the ***Plan***, the ***employer*** in no way guarantees employment for any ***employee***. Participation in this ***Plan*** shall in no way assure continued employment with the ***employer***.

TAX EFFECTS

Neither the ***employer*** nor the ***Plan Administrator*** makes any warranty or other representation as to whether any payments made hereunder will be treated as includable or excludible in gross income for federal or state income tax purposes.

ADDRESS, NOTICE AND WAIVER OF NOTICE

Each ***participant*** shall furnish the ***employer*** with his correct post office address. Any communication, statement or notice addressed to a ***participant*** at his last post office address as filed with the ***employer*** will be binding on such person. The ***employer*** or ***Plan Administrator*** shall be under no legal obligation to search for or investigate the whereabouts of any person benefiting under this ***Plan***. Any notice required under the ***Plan*** may be waived by such person entitled to such notice.

SEVERABILITY

In any case where any provision of the ***Plan*** is held to be illegal or invalid, such illegality or invalidity shall apply only to that part of the ***Plan*** and shall not apply to any remaining provisions of the ***Plan***, and the ***Plan*** shall be construed as if such illegal or invalid provision had never existed under the ***Plan***.

APPLICABLE LAW

The ***Plan*** shall be construed under the laws of the Commonwealth of Pennsylvania, to the extent not preempted by any Federal law.