Plan Document
Franklin & Marshall College
Health Reimbursement Account

Table of Contents

Section 1: Establishment of HRA Plan

1.1 Establishment of Plan.
Franklin & Marshall College (the "Employer") hereby establishes a Health Reimbursement Account effective on the date shown on the attached Health Reimbursement Account Adoption Agreement for the exclusive benefit of its Employees (and the Employees of its Affiliates) who are employed on or after the Effective Date.

1.2 Plan Year.
The Plan Year for this Plan is shown on the attached Health Reimbursement Account Adoption Agreement.

1.3 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 both as a nondiscriminatory health reimbursement arrangement under Notice 2002-45 of the Code and as an accident and health care reimbursement arrangement 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.

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

Section 2: Definitions

2.1 Administrator.
Administrator means the Employer.

2.2 Affiliates.
Affiliates include (1) any subsidiary or affiliated or associated corporation of the Employer, which together with the Employer is a member of a controlled group of corporations; and (2) any organization which together with the Plan Administrator is under "common control" or an "affiliated service group" as those terms are used in sections 414(b), 414(c) and 414(m) of the Code.

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

2.4 Claims Administrator.
Claims Administrator means the entity designated by the Employer to adjudicate claims.

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

2.6 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.

2.7 Employee.
Employee means any common law employee of the Employer who is regularly scheduled to work for remuneration that 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 employee covered under a collective bargaining agreement (unless the collective bargaining agreement provides that this plan is applicable); (4) any self-employed individual; and (5) 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.

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

2.9 Health Plan.
Health Plan means the employee PPO Health Plan $1,500 welfare benefit plan which is designated by the Employer to include this Health Reimbursement Account.

2.10 HRA Plan.
HRA plan means the Employer Health Reimbursement Account, as amended from time to time.

2.11 Participant.
Participant means an Employee who satisfies the requirements of Section 3.1 of the Plan and who is eligible for and elects coverage under the Health Plan.

2.12 Plan.
Plan means this HRA Plan.

2.13 Plan Administrator.
Plan Administrator means the Employer.

2.14 Plan Year.
Plan Year means the twelve-month period shown on the Health Reimbursement Account Adoption Agreement.

2.15 Qualifying Medical Expenses.
Qualifying Medical Expenses shall have the meaning given to it in Section 5.5 of this Plan Document.

2.16 Reimbursement Account.
Reimbursement Account means a recordkeeping account established for designated contributions made by the Employer on behalf of the Participant for reimbursement of Qualifying Medical Expenses. All amounts held in such account are general assets of the Employer. The amount made available by the Employer for each Participant's Reimbursement Account is described in the Summary Plan Description which is incorporated into this Plan Document by reference.

2.17 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.

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

Section 3: Eligibility and Termination

3.1 Employee Eligibility for this HRA Plan.
Generally, an Employee shall be eligible to participate in this HRA Plan if 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 HRA Plan on the date that coverage is effective for the Participant under the Health Plan.

3.2 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 HRA Plan with the same Reimbursement Account balance that the individual had before termination, pending reinstatement in the Health Plan, as explained in the certificate of coverage.

In addition, retired employees, surviving spouses and/or eligible dependents of retired employees, and surviving spouses and/or eligible dependents of active employees who terminate their HRA coverage will have the option to spend down any balance remaining in the account at the time of termination for a period of four years. If a retired employee dies, their surviving spouse and/or eligible dependents would only be able to spend down the balance for the balance of the four years from the date of the employee's retirement. If an active employee dies, their surviving spouse and/or eligible dependents would be able to spend down the balance for four years from the date of the active employee's death.

3.3 Termination of Participation in this HRA Plan
A Participant will cease to be a Participant in this HRA Plan upon the earlier of:
- The termination of this HRA Plan; or
- The date that the Employee or Dependent is no longer enrolled in the Health Plan.

Any expenses incurred by a Participant or Dependent after termination of participation in this HRA Plan will not be payable by this HRA Plan, except as permitted in accordance with Section 3.7 below.

3.4 FMLA, USERRA and Other Leaves of Absence.
Notwithstanding any provision to the contrary in this HRA Plan, 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 Reimbursement Account on the same terms and conditions as if the Participant were still an active employee. Continued coverage under this HRA Plan for employees who are on other leaves of absence will be determined in accordance with the policies of the Employer.

If an employee reenrolls in the Health Plan immediately upon returning to work after a sabbatical, research or other medical leave of absence, the HRA account balance will be restored.

3.5 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.

3.6 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 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 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 Administrator will also send a description of the coverage.

After sending the notice of receipt, the 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 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.

3.7 COBRA Continuation Coverage.

If a Participant's or Dependent's coverage under this HRA 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 HRA 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 the Plan must notify the 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 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 Administrator. Finally, a Participant must notify the Administrator of the start or end of any disability that is determined under the Social Security Act to be a covered disability. The 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 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 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 Plan. You can contact the Administrator if you need another copy.

Section 4: Changes to Elected Coverage

4.1 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.

If an employee adds or drops dependents from coverage during a Plan Year (as permitted under the terms of this Plan and the PPO Health Plan $1,500) his/her HRA balance will be increased for the added dependent, but not decreased as a result of the dropped dependent.

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

4.3 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 5: Benefits

5.1 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 following dollar amount of coverage shown in the Summary Plan Description or any amendments to that document.

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

5.2 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 in the Reimbursement Account for a Plan Year, any amount remaining in the Participant's Reimbursement Account as of the end of the Plan Year will be carried forward to the next Plan Year as long as the employee remains enrolled in the PPO Health Plan $1,500 (High Deductible Health Plan) and only if specified in the attached Health Reimbursement Account Adoption Agreement.

5.3 Forfeiture at Termination.
Amounts remaining in a Participant's Reimbursement Account after September 30th following termination, shall be forfeited. If a Dependent terminates coverage during a Plan Year, the Participant's account will not be re-adjusted until the next Plan Year.

5.4 Benefits Limited to Expenses Incurred During Plan Year.
The Participant's Reimbursement Account funds 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.

5.5 Qualifying Medical Expenses.
Qualifying Medical Expenses shall include those expenses that are shown on the Health Reimbursement Account Adoption Agreement.

5.6 Coordination of Benefits; FSA Plan to Reimburse First
Benefits under this Plan are intended to pay benefits solely for Qualifying Medical Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Qualifying Medical Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan. Without limiting the foregoing, if the Participant's Qualifying Medical Expense is covered by both this Plan and the FSA Plan, then this Plan is not available for reimbursement of such expense until after amounts available for reimbursement under the FSA Plan have been exhausted.

5.7 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.

5.8 Refund of Duplicate Reimbursements.
If a Participant receives a reimbursement under this HRA Plan and reimbursement for the same expense is made under another plan, he will be required to refund the reimbursement to the Employer. The amount of the Participant's Reimbursement Account, to the extent of any such refund, shall be reinstated for the Plan Year in which the reimbursement was originally made. Any amount not refunded becomes taxable income to the Employee.

Section 6: HRA Administration

6.1 General.
The Administrator shall have complete control of the administration of this HRA 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 the Plan.

6.2 Duties and Policies of the Administrator.

The 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 on a schedule determined by the Employer a written statement showing the total reimbursements to the Participant under the Plan;
(1) To correct any reimbursement of expenses made in error; and
(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 7: HRA Plan Claims Procedures

7.1 Submission of HRA Claims.

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

- The person or persons 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 Administrator will be paid within 30 days after receipt of the appropriate documentation, or as soon as possible thereafter. Claims for expenses incurred during a Plan Year may be filed up to ninety days following the end of the Plan Year.

All claims for Participants or who have a Termination who lose eligibility must be filed within ninety days after the Termination or loss of eligibility.

7.2 Denials of HRA Claims.

If the Claims 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 immediately 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 Claims 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 as soon as possible but not later than 24 hours for urgent claims). Such notice shall set forth the following information:

(a) Information that is sufficient to identify the claim involved (including date of service, name of health care provider, claim amount, diagnosis code and its meaning, and the treatment code and its meaning)
(b) The specific reason or reasons for the denial, including a description of the meaning of any denial code;
(c) Specific reference to pertinent Plan provision, internal rule, guideline, protocol or similar criteria on which the denial is based;
(d) A description of the available internal appeals and external review processes, including information on how to initiate an appeal;
(e) Information about the availability of any health insurance consumer assistance or ombudsman to assist with appeals, including contact information; and
(f) An explanation that a full and fair review of the decision denying the claim (including the right to present evidence and testimony) may be requested by the claimant or his authorized representative by filing an appeal 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 Claims 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 Claims Administrator will provide the claimant with any new or additional information that was considered, relied upon or generated in connection with the claim. This information will be provided in advance of the final determination so that the claimant has a reasonable opportunity to respond prior to that date.

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 relevant Plan provisions on which the denial is based. The notice of denial will include a discussion of the decision.

Upon exhaustion of the internal review process (or earlier if the Claims Administrator does not follow the requirements of the applicable law), the claimant has the right to initiate an external review of the denial. The Claims Administrator will provide a description of the applicable external appeal process.

Section 8: HRA Plan Funding

All benefits paid under this HRA Plan shall be payable directly to applicable Participants or providers of service 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 9: 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 10: Privacy and Security

This Section applies only to the extent that the health plan is subject to HIPAA (if the Employer has 50 or more Participants regardless of how claims are paid or contracts with a third party administrator to administer and/or pay claims.)

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 11: Miscellaneous

11.1 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.

11.2 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.

11.3 Choice of Law.
This HRA 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.

11.4 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.

11.5 Gender, Singular and Plural References.
References in this Plan Document 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.