Moore College of Art and Design
MEDICAL EXPENSE REIMBURSEMENT PLAN
AND SUMMARY PLAN DESCRIPTION

Effective Date: June 1, 2009

1. **Moore College of Art and Design.** (the "College") maintains the Moore College Medical Reimbursement Plan (the "Plan") for the exclusive benefit of eligible employees and their spouses and dependents. Under the Plan, an employee can be reimbursed by the College for up to $250 in qualifying medical expenses incurred in a Plan Year by the employee or the employee's spouse or dependents, provided that the expenses are not otherwise reimbursed by insurance or other reimbursement programs.

2. **General Information About the Plan.**

Plan Name:	Moore College of Art and Design Medical Expense Reimbursement Plan.
Type of Plan:	Welfare benefit plan providing reimbursement for certain qualifying medical expenses.
Effective Date:	Shall mean the period of twelve consecutive months commencing each June 1 and ending on the following May 31.
Plan Year:	June 1 – May 31
Plan Number:	# 503
Funding Medium:	Benefits are paid directly out of the general assets of the College. There is no special fund or trust from which benefits are paid.
Source of Contributions:	The College bears the entire cost of this Plan. Employees do not make contributions (by salary reduction or otherwise), except that former employees who elect COBRA coverage must pay for that coverage.
Plan Sponsor and Named Fiduciary:	Moore College of Art and Design 20th Street and The Parkway Philadelphia, PA 19103-1179 EIN 23-1352236
Plan Administrator:	Moore College of Art and Design 20th Street and The Parkway

	Philadelphia, PA 19103-1179 Attention: Vice President of Finance & Administration
Type of Plan Administration:	The Plan is self-administered by the College. Claims are submitted to the HR Manager, who acts on behalf of the Plan Administrator. Reimbursements are made pursuant to the terms of this Plan document, which also serves as the Summary Plan Description.
Agent for Service of Legal Process:	Vice President of Finance & Administration Moore College of Art and Design 20th Street and The Parkway Philadelphia, PA 19103-1179 (215) 965-4021

3. **Eligibility and Participation Requirements.** You are eligible to participate in the Plan if you are regularly scheduled to work for the College at least thirty (30) hours per week and you have been employed by the College for at least ninety (90) days. You are not eligible to participate, however, if you are classified by the College as a leased employee (whether or not you meet the definition of leased employee in Section 44(n) of the Internal Revenue Code (the "Code")), a temporary employee, a contract employee, or an independent contractor, whether or not you are paid W-2 wages.

You will actually commence participation in the Plan on the first of the month that immediately follows your completion of ninety (90) days of employment by the College, if you are still employed by the College on that June 1. You will not need to apply to participate in the Plan; enrollment in the Plan will be automatic for all employees who meet the eligibility requirements set forth in this section.

Employees who satisfied the eligibility requirements of the Plan on the effective date of the Plan will commence participation in the Plan on the effective date of the Plan.

Your eligibility for Plan benefits will terminate on the earliest of the following dates: (i) the date of your termination of employment with the College, (ii) the date you cease to be an employee eligible to participate in the Plan, whether because of layoff, reduction in hours, or any other reason, or (iii) the date of termination of the Plan.

If your participation terminates, your right to receive reimbursement for qualifying expenses under the Plan will generally be revoked. However, you will still have the right to receive reimbursement for qualifying medical expenses that were incurred prior to your termination of participation, if you apply for reimbursement within sixty (60) days after the close of the Plan Year during which your participation terminated.
Family and Medical Leave Act of 1993. If you go on a qualifying unpaid leave under the Family and Medical Leave Act of 1993 ("FMLA"), the following rules will apply. To the extent required by the FMLA (among other things, this means only for the duration of

a qualifying leave), the College will continue to provide benefits for you under the Plan on the same terms and conditions as though you were still an active employee. Except as otherwise provided in the FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave. Your Plan participation will immediately cease on expiration of your FMLA leave, if you fail to return to work at such time.

COBRA. If your participation in the Plan ceases, you may have the right to continue your benefits under the Plan following the occurrence of certain "qualifying events" that would otherwise result in loss of coverage in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). These rights are described in the "Summary of Rights and Obligations Regarding Continuation of Group Health Plan Coverage" which has been previously furnished to you. Please contact the Human Resources Manager of the College if you need another copy of this summary. You may not elect under COBRA to continue your benefits under this Plan unless you also elect under COBRA to continue your benefits under the College's health insurance plan.

4. **Plan Benefits.** For the 12 month plan year of June 1 to May 31, you can receive reimbursement under the Plan for up to $250 of expenses incurred for medical care (as defined in Code Section 213) by you, your spouse, or your dependant during a Plan Year, but only if those expenses cannot be paid or reimbursed.

If you incur inpatient hospital co-pays up to $500, you may also receive reimbursement annually under the Plan.

Expenses for medical care include, among other things, expenses for dental care and prescribed drugs. However, you ***cannot*** be reimbursed under the Plan for any of the following items:

- Any expense which is covered by a health insurance policy (except to the extent that such expense will not be paid or reimbursed by the insurer because of the policy's deductible or co-payment provisions).
- Any premiums you pay for other health coverage.
- Transportation expenses.
- Over-the-counter medicines.
- Vitamins or dietary supplements.
- Massage therapy.
- Exercise programs, health club or spa memberships.
- Stop-smoking or weight-loss programs, medication or treatments.
- Cosmetic surgery or similar expenses, except that qualifying medical expenses include expenses for cosmetic surgery or other similar procedures which are necessary to ameliorate a deformity arising from, or directly

- Long-term care services (as defined in Code Section 7702B(c)).

- Any expense which could be reimbursed from the unexpected balance of your flexible spending account under the Moore College of Art and Design Cafeteria Compensation Plan.

A child or other person qualifies as your "dependant" for purposes of the Plan if and only if he or she qualified as your 'dependant" for federal income tax purposes, as defined in Section 152 of the Code (as modified by the last sentence of Section 105(b) of the Code).

A medical expense is "incurred" when the related medical care or service is furnished, not when you are billed or pay for the expense.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 (or 96) hours.

If you have a question about whether a particular medical expense is or is not reimbursable under the Plan, you should contact that Plan Administrator. The Plan Administrator has discretionary authority to determine what expenses are reimbursable, taking into account the terms of this Plan, rules contained in applicable sections of the Code and regulations, and other IRS guidance thereunder.

5. **Reimbursement Procedure.** When you incur a claim for which you wish to be reimbursed, you must submit to the Human Resources Manager, who acts on behalf of the Plan Administrator, a written claim on the form provided for this purpose. The form will require you to provide the information and documentation necessary to determine whether your claim qualifies for reimbursement (including a written statement from an independent third party stating that the medical expense has been incurred, and a written statement from the participant that the medical expense has not been reimbursed and is not reimbursable under any health insurance policy or other health plan coverage). The Plan Administrator may amend or modify the required form or required use of a different form at any time.

All claims for reimbursement for expenses incurred during a Plan Year must be submitted to the Plan Administrator within 30 days after the close of such Plan Year.

The Plan Administrator will not reimburse a claim for expenses incurred during a Plan Year to the extent that such claim, when combined with claims previously reimbursed under the Plan for expenses incurred during the Plan Year, exceeds $250.

Unused benefits under the Plan for a particular Plan Year cannot be carried over to any later Plan Year.

6. **Plan Administrator.** The administration of the Plan is under the supervision of the College, which is the Plan Administrator of the Plan. The Human Resources Manager of the College acts on behalf of the Plan Administrator. If you have any general questions regarding the Plan, please contact the Human Resources Manager.

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator is responsible for determining eligibility for and the amount of any benefits payable under the Plan, and prescribing procedures to be followed and the forms to be used by employees pursuant to the Plan. The Plan Administrator also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan. The Plan Administrator has the discretionary authority to interpret the Plan and to resolve ambiguities under the Plan. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The College bears all costs of administering the Plan.

7. **Circumstances Which May Affect Benefits.** Your benefits will cease on the day you terminate from employment with the College, unless they are extended under a COBRA election. Your benefits will also cease on termination of the Plan, or on your ceasing to be an eligible employee for any reason.

You will not be reimbursed for any medical expenses unless they are qualifying expenses. The Plan Administrator will deny claims for reimbursement which it determines are not qualifying expenses.

8. **Amendment or Termination of the Plan.** The College has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument signed by the President or other authorized officer of the College.

9. **No Contract of Employment.** The Plan is not intended to be and may not be construed as constituting, a contract or other arrangement between you and the College to the effect that you will be employed for any specific period of time.

10. **Benefit Denials and Appeals Procedure.** The Plan Administrator is responsible for evaluating all claims for reimbursement under The Plan.

The Plan Administrator will decide your claim within a reasonable time not longer than thirty (30) days after it is received. This time period may be extended for an additional fifteen (15) days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete. You will receive written notice of any extension, including the reasons for the extension and information on the date by which a decision

by the Administrator is expected to be made. You will be given forty-five (45) days in which to complete an incomplete claim. The Plan Administrator may secure independent medical or other advice and require such other evidence as it deems necessary to decide your claim.

If the Plan Administrator denies your claim, in whole or in part, you will be furnished with a written notice of adverse benefit determination setting forth:

1. The specific reason or reasons for the denial,

2. Reference to the specific Plan provision on which the denial is based.

3. A description of any additional material or information necessary for you to complete your claim and an explanation of why such material or information is necessary, and

4. Appropriate information as to the steps to be taken if you wish to appeal the Plan Administrator's determination, including your right to submit written comments and have them considered, your right to review (on request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

If your claim is denied in whole or in part, you may appeal to the Plan Administrator for a review of the denied claim. Your appeal must be made in writing within one hundred eighty (180) days of the Plan Administrator's initial notice of adverse benefit determination, or else you will lose the right to appeal your denial. If you do not appeal on time, you will also lose your right to file suit in court, as you will have failed to exhaust your internal administrative appeal rights, which is generally a prerequisite to bringing suit.

Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information relevant to your appeal. The Plan Administrator will review all written comments you submit with your appeal.

The Plan Administrator will review and decide your appeal within a reasonable time not longer than sixty (60) days after it is submitted and will notify you of its decision in writing. The individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate. The Plan Administrator may secure independent medical or other advice and require expert consulted in connection with your initial claim. (The identity of a medical expert consulted in connection with your appeal will be provided.) If the decision on appeal affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

1. The specific reason(s) for the denial,

2. The specific Plan provision(s) on which the decision is based.

3. A statement of your right to review (on request and at no charge) relevant documents and other information,

4. If the Plan Administrator relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request, and

5. A statement of you right to bring suit under ERISA Section 502(a).

11. **Federal Income Tax.** The Plan is intended to qualify as a "self-insured medical reimbursement plan" under Section 105(h) of the Code, and reimbursements of qualifying medical expenses under the Plan are intended to be eligible for exclusion from participating employees' gross income for federal income-tax purposes under Section 105(b) of the Code. Benefits for which you receive reimbursement cannot be deducted as a medical expense on your federal income tax return.

12. **Statement of ERISA Rights.** As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest annual report (Form 5500 Series), if any, and the updated Plan and Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

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

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without

charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

COBRA Rights. You have a right to continue health care coverage for yourself if there is no loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. The rules governing these rights are set forth in "Summary of Rights and Obligations Regarding Continuation of Group Health Plan Coverage," a copy of which has been previously furnished to you. Please contact the Plan Administrator if you need another copy of this summary.

The Plan and Plan Sponsor also are subject to HIPPAA privacy requirements (the "Privacy Rule") as "covered entities." Pursuant to the Privacy Rule, the Plan Sponsor agrees as follows:

- To not use or further disclose "Protected Health Information" ("PHI") as defined in the Privacy Rule, other than as permitted hereby;

  (For purposes of this provision, the "Plan Documents" includes this Plan document and the "HIPPAA Privacy Documents," as further identified below, which are incorporated herewith.)

- To ensure that any agents or subcontractors to whom it provides PHI received from the Plan agree to the same restrictions and conditions as they apply to them;

- To not use or disclose PHI for any employment-related actions or in connection with any other employee benefit not within this Plan;

- To report to the Plan Administrator's Privacy Officer, as designated in the HIPPAA Privacy Documents, any use or disclosure of PHI that is inconsistent with permitted uses and disclosures as defined in the HIPPAA Privacy Documents;

- To make individuals' PHI available to Plan participants, to consider their amendments, and, upon request, to provide individual participants with an accounting of disclosures of their PHI (as further detailed in the HIPPAA Privacy Documents);

- To make its internal practices and records relating to the use and disclosure of PHI received from the Plan available to the federal Department of Health and Human Services upon request;

- If feasible, to return or destroy all PHI received from the Plan or other HIPPAA group health plan that it still maintains in any form, and to retain no copies of such information when it is no longer needed for the purposes for which disclosure was made, except that if such return or disclosure is not feasible, the Plan Administrator shall limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible;

- To certify to the Privacy Officer that (a) the Plan Documents include these requirements and each of this Plan and the Plan Administrator agrees with these requirements; and (b) that the Plan Administrator has provided adequate "firewalls" in accordance with the Privacy Rule; and

- To create and maintain the HIPPAA Privacy Documents as identified below."

The "HIPPAA Privacy Documents" shall be the Plan Administrator's.

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