

DREXEL UNIVERSITY COLLEGE OF MEDICINE

CAFETERIA PLAN

AND

SUMMARY PLAN DESCRIPTION

As of January 1, 2012

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INTRODUCTION

Philadelphia Health & Education Corporation d/b/a Drexel University College of Medicine (“DUCOM”) established the Drexel University College of Medicine Cafeteria Plan and Summary Plan Description (the “Plan”) to allow its eligible faculty and staff members (1) to purchase certain benefit coverage on a tax-favored basis through payroll reduction, and (2) to set aside amounts through payroll reduction to reimburse themselves for eligible health care and/or dependent care expenses. This document sets forth the terms of the Plan as in effect on January 1, 2012.

This document serves two important functions related to the Plan under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”), a federal law applying to employee benefit plans:

First, ERISA requires that employers provide eligible employees with a description of the various benefit plans it maintains. Such information is to be included in a summary plan description (“SPD”) for each plan. This document constitutes the SPD for the Plan.

Second, ERISA requires that employee benefit plans be maintained pursuant to a written plan document. This document constitutes the written plan document under ERISA.

You and your beneficiaries may examine the Plan, all amendments, and certain other documents and records pertaining to the Plan during regular business hours or by appointment at a mutually convenient time with the Human Resources Department. You may obtain copies of the Plan and of certain reports from the Human Resources Department (a reasonable charge may be imposed for those copies, as prescribed by federal regulation). Because benefits under the Plan will be of importance to you and your family, you should retain this document as part of your permanent records.

The Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with DUCOM and does not give you the right to be retained in the employment of DUCOM.

PURPOSE OF THE PLAN

The purpose of the Plan is to allow you to use a portion of your salary, on a pre-tax basis, to purchase certain benefit coverage for yourself and/or your family. The Plan also permits you to establish flexible spending accounts (“FSAs”) that you may use to reimburse yourself for eligible health care and/or dependent care expenses incurred by you and your family. DUCOM intends that the Plan qualify as a “cafeteria plan” within the meaning of Section 125(c) of the Internal Revenue Code of 1986, as amended (the “Code”), and that the premiums you pay for the health care coverage option you elect, your contributions to the FSA that you establish under the Plan and reimbursement for out-of-pocket medical and/or dependent care expenses be eligible for exclusion from your income for federal income tax purposes.

ELIGIBILITY AND PARTICIPATION

Eligible Employees. All regular full-time and part-time staff and faculty of DUCOM are eligible to participate in the Plan on the first day of the month on or following date of hire. However, eligibility for benefit coverage is determined under the DUCOM Health and Welfare Plan. Please refer to this document to determine whether you are eligible for medical, prescription drug, dental and other health and welfare benefits. The following individuals are ineligible to participate in the Plan: (1) temporary employees; (2) those who perform services for DUCOM pursuant to an arrangement with a leasing organization, including but not limited to “leased employees” within the meaning of section 414(n) of the Code; (3) those who are not on the DUCOM payroll, whether or not they are later determined to be an employee of DUCOM; (4) other non-regular employees as determined in accordance with DUCOM’s personnel policies and practices.

Participation. Once you make an election to participate in the Plan, you may change that election only (1) if you have a change in status, as described below under “Coverage Options And Enrollment,” or (2) during an open enrollment period, for the first day of the next succeeding “Plan Year.” The Plan Year for the Plan is January 1 to December 31. If you fail to make an election for benefits upon your initial eligibility for coverage, you will be deemed to have elected no benefits. Therefore, it is extremely important that you return all election materials within the time period prescribed by DUCOM.

Recommendation of Participation. If you terminate employment or otherwise cease to be an eligible employee and again become an eligible employee, you will be permitted to make new elections under the Plan after you again satisfy the eligibility requirements described above.

COST OF THE PLAN

If you are required to contribute toward the cost of the coverage you elect under the DUCOM Health and Welfare Plan or if you elect to establish an FSA, you are required to contribute a portion of your compensation for such coverage pursuant to a voluntary salary reduction agreement. The amount you contribute to an FSA is up to you (within Plan limits). The amount you may be required to contribute toward other coverage is determined by DUCOM each year and may change from time to time to reflect any increases or decreases in the cost of coverage. If you elect medical, prescription drug, dental and/or vision coverage or if you establish a Health Care or Dependent Care FSA, your contributions will be deducted from your pay, before federal income taxes, state income taxes (except New Jersey and, if you are a resident of Pennsylvania, contributions to a Dependent Care FSA) or Social Security taxes are withheld (some local income/wage taxes may apply), meaning that you purchase coverage with more valuable pre-tax dollars. Therefore, you will be taxed on a slightly lower gross income and your taxes will be lower. Because your pre-tax contributions are not subject to Social Security taxes, your Social Security benefit at retirement may be slightly reduced if your earnings are under the Social Security Taxable Wage Base (\$110,100 for 2011). However, the reduction in Social Security benefits should be more than offset by the tax savings under the Plan.

Medical, prescription drug, dental and vision coverage can be paid with pre-tax dollars for you, your spouse, your eligible dependents, including, but not limited to, your natural born child,

legally adopted child, step child and foster child up to age 26. This Plan only sets forth the tax rules applicable to medical, prescription drug, dental and vision coverage. The eligibility rules for such coverage are described in the Drexel University College of Medicine Health and Welfare Plan and Summary Plan Description.

CESSATION OF PARTICIPATION

Coverage under the Plan will terminate automatically as of the date of your termination of employment or loss of eligibility. In addition, coverage will terminate as of the first to occur of the following:

- the date all coverage or certain benefits are terminated for your particular employment classification, due to a modification of the Plan;
- the last day of the last period for which any required contribution toward the cost of coverage was made; or
- the date the Plan terminates.

DUCOM may continue coverage during certain periods of absence, such as a leave of absence under the Family and Medical Leave Act of 1993, in accordance with its written personnel policies and practices. DUCOM may require contributions during periods of absence in accordance with its written personnel policies and practices.

COVERAGE OPTIONS AND ENROLLMENT

During each annual open enrollment period, you will be given the opportunity to make your benefit choices for the upcoming Plan Year (January 1 through December 31). Except as provided in the following sentence, if you do not elect to change your medical, dental, and/or vision coverage from the previous year, DUCOM assumes that you want to continue under the same elections, unless DUCOM determines that reenrollment will be required for a particular Plan Year. However, to contribute to a Dependent Care FSA or a Health Care FSA, you must make an election for each Plan Year. FSA elections will not carry over from year to year.

Generally, you may not make changes to your coverage elections during the Plan Year. (This restriction is due to requirements under federal law.) You may, however, make a change to an election that is on account of and consistent with one of the events described below. If you have a change in family or work status -- sometime referred to as a "Life Event" -- or under certain other circumstances, you may join, re-join, opt out, increase or decrease coverage (*e.g.*, change from employee to family coverage or vice versa) if you notify DUCOM within 31 days of the change. The following list describes circumstances that may permit you to make a mid-year election change.

If one or more of the following Life Events occur, you may revoke your old election during the year and make a new election; provided, that both the revocation and new election are on account of and correspond with the Life Event (as described below). Those occurrences that

qualify as Life Events include the events described below, as well as any other events that the Plan Administrator determines are permitted under applicable regulations:

- Change in Marital Status -- a change in your legal marital status (such as marriage, legal separation, annulment, divorce or death of your spouse),
- Change in Number of Dependents -- a change in the number of your dependents (such as the birth of a child, adoption or placement for adoption of a dependent, or death of a dependent),
- Change in Employment Status -- any of the following events that change the employment status of you, your spouse or your dependent that affects benefit eligibility under an employee benefit plan (including this Plan) of you, your spouse or your dependents. Such events include any of the following changes in employment status: termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, switching between part-time and full-time, incurring a reduction or increase in hours of employment, or any other similar change that makes the individual become (or cease to be) eligible for a particular benefit under the Plan,
- Change in Dependent Eligibility -- an event that causes your dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit, such as attainment of age, student status, or any similar circumstance, or
- Change in Residence -- a change in your, your spouse's or your dependent's place of residence.

If a Life Event occurs, you must inform the Plan Administrator and complete a Change of Status form within 31 days of the Life Event. Your coverage change will be effective on the first day of the month after you provide timely notice to the Plan Administrator. However, if the Life Event is a birth, adoption, or placement for adoption of a dependent child, coverage will be retroactively provided to the date of the event, again subject to timely notice of the event.

If you wish to change your election based on a Life Event, you must establish that the revocation of your existing election and the new election are on account of and correspond with the Life Event. The Plan Administrator (in its sole discretion) shall determine whether a requested change is on account of and corresponds with a Life Event, as described in applicable regulations. As a general rule, a desired election change will be found to be consistent with a Life Event if the event affects coverage eligibility and the change responds to that election change. (This means, for example, that you may be limited to adding or dropping dependents, rather than changing coverage options.) In addition, you must also satisfy the following specific requirements in order to alter your election based on the Life Event:

- Life Event Involving Loss of Dependent Eligibility -- A special rule governs which type of election change is consistent with the Life Event. For a Life Event involving (a) divorce, annulment or legal separation from your spouse, (b) the death of your spouse or your dependent or (c) your dependent ceasing to satisfy the eligibility requirements for

coverage, your election to cancel coverage for any individual other than a person losing eligibility as a result of the event would fail to correspond with that Life Event.

- **Life Event Involving Coverage Eligibility Under Another Plan** -- For a Life Event in which you, your spouse or your dependent gain eligibility for coverage under another employer's plan as a result of a change in your marital status or a change in your, your spouse's or your dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Life Event only if coverage for that individual becomes effective or is increased under the other employer's plan.

Special Enrollment Rights. If you, your spouse and/or a dependent are entitled to special enrollment rights under a group health plan, you may change your election to correspond with the special enrollment right. Thus, for example, if you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (*i.e.*, due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect medical coverage under the Plan for yourself and your eligible dependents who lost such coverage. Furthermore, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your spouse, and your newly acquired dependents; provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Please refer to the Drexel University College of Medicine Health and Welfare Plan and Summary Plan Description for an explanation of special enrollment rights.

Certain Judgments and Orders. If a judgment, decree or order, including a Qualified Medical Child Support Order (QMCSO), resulting from a divorce, separation, annulment or custody change requires your dependent child (including a foster child who is your tax dependent) to be covered under this Plan, you may change your election to provide coverage for the dependent child. The child must otherwise meet the Plan's definition of a dependent (*e.g.*, the age requirement). If the order requires that another individual (such as your former spouse) cover the dependent child, you may change your election to revoke coverage for the dependent child.

Entitlement to Medicare or Medicaid. If you, your spouse, or a dependent actually enroll in Medicare or Medicaid, you may cancel that person's medical coverage. Similarly, if you, your spouse, or a dependent who has been enrolled in Medicare or Medicaid loses eligibility for the same, you may, subject to the terms of the underlying plan, elect to begin that person's medical coverage.

Changes Related to Dependent Care. You may make an election change to the contribution to your Dependent Care Spending Account that is due to a change in the cost of dependent care, so long as the dependent care provider is not your relative. In addition, you may make an election change to the contribution to your Dependent Care Spending Account that is due to a change in dependent care provider.

Change in Coverage. If the Plan Administrator notifies you that your coverage under the Plan will be *significantly* curtailed during the Plan Year, you may revoke your election and elect

coverage under another plan option that provides similar coverage. You may also revoke your election if there is a *significant* curtailment that amounts to a loss of coverage (e.g., an HMO ceases to be available) and there is no other benefit option that provides similar coverage. However, if there is a *significant* curtailment that does not amount to a loss of coverage (e.g., an increase in deductibles or co-payments), you may not drop your coverage but only switch to a similar coverage. Also, if during the Plan Year the Plan adds or eliminates a benefit option, you may elect the newly-added option or elect another benefit option (when a Plan option has been eliminated). Additionally, you may make an election change when there is a significant improvement in coverage provided under an existing benefit option. Finally, you may make an election change that is on account of and corresponds with a change made under the plan of your spouse's, former spouse's or dependent's employer, so long as: (a) his or her employer's plan permits its participants to make an election change permitted under applicable regulations; or (b) the plan year of the other plan is other than January 1 - December 31.

Except as provided in the last two items above, in no event are you permitted to change health insurance providers during the Plan Year. Such a change may take place only during the annual open enrollment period prior to each Plan Year. (The "Change in Coverage" exceptions described in this section do not apply to the Health Care FSA).

BENEFITS

This section provides complete descriptions of the Health Care and Dependent Care FSAs available under the Plan and describes some important rules regarding your annual elections under the Plan. Health coverage (medical, prescription drug, dental and vision) is described in the Drexel University College of Medicine Health and Welfare Plan and Summary Plan Description, which is available in the Human Resources Department.

Flexible Spending Accounts (FSAs):

Highlights: The FSAs (Health Care FSA and Dependent Care FSA) provide valuable benefits designed to give you an effective way to reimburse yourself on a tax-free basis for certain health care and dependent care expenses. The Health Care FSA is designed to help you pay certain health care expenses that you and your family may incur. The Dependent Care FSA is intended to qualify as a dependent care assistance benefit within the meaning of Section 129 of the Code and help you pay qualified dependent care expenses.

Before the Plan Year begins, or when you first meet the Plan's eligibility requirements, you may elect to have a portion of your pay placed in either or both FSAs on a pre-tax basis. You estimate the amounts that you will require in each account for the year and divide the result by the number of pay periods for the year. This equal amount will be deducted from your gross pay each pay period **before taxes**. You may contribute up to \$5,000 to a Health Care FSA and up to \$5,000 to a Dependent Care FSA. (Please note that beginning January 1, 2013, you cannot contribute more than \$2,500 to a Health Care FSA as required by federal law.) If you establish an FSA, you can use "untaxed" money to pay for services that you would otherwise pay for with after-tax dollars.

Remember, it is important that you be **conservative** when estimating your expenses for the next Plan Year. IRS regulations state that any money set aside in these accounts not used for expenses incurred during the same year must be **forfeited. THE DOLLARS CANNOT BE RETURNED TO YOU**. This is the “use it or lose it” rule required by the IRS. Please note that you will not be entitled to receive interest or any other earnings on contributions allocated to your FSA(s).

In summary:

- Dollars you place in your Health Care and/or Dependent Care FSA(s) are taken out of your pay **before** they are taxed;
- The money in your FSA can only be used to reimburse eligible expenses incurred in the same Plan Year;
- You will not be entitled to receive interest or any other earnings on contributions made to your FSA(s);
- Money in one FSA cannot be used to pay for items covered by the other FSA;
- Money in one FSA cannot be transferred to the other FSA;
- Claims for your Dependent Care FSA and Health Care FSA are paid by the third party administrator as soon as is practicable. You have up to 90 days following the end of a Plan Year (until March 31) to submit claims to either FSA for expense incurred during that Plan Year. If you terminate your employment, you will have up to 90 days following the end of the Plan Year (until March 31) in which you terminate to submit claims for expenses incurred during the Plan Year to the third party administrator but before your date of termination (unless you elect COBRA for your Health Care FSA).

Here are a few other key considerations to keep in mind when evaluating and planning participation in your FSA:

- Your eligible and **predictable** health care expenses;
- Your eligible child-care expenses;
- Your gross income (including your spouse’s income) and tax bracket; and
- Your ability to afford a reduction in your paycheck, as part of your salary will be set aside for expenses.

Health Care FSA: The Health Care FSA may be used to pay any health care expense that would qualify for a medical deduction under IRS rules, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by the employer of your spouse or dependent) and certain long-term care expenses. Generally, the expenses covered must be “medically necessary” or prescribed by a licensed physician to qualify. Of course, health care expenses reimbursed through your Health Care FSA cannot be claimed as an additional deduction for income tax purposes. Expenses must be incurred on behalf of you, your spouse and any dependent with respect to whom you are entitled to claim a deduction on your federal income tax return. Expenses can also be incurred by your natural born child, legally adopted child, step child or foster child up to age 26. If you do not claim your same-sex domestic partner and/or his or her children as dependents, you cannot request reimbursement under the Health Care FSA for their health care expenses.

In the case of a child who receives over one-half of his or her support during the calendar year from his or her parents (i) who are divorced or legally separated under a decree of divorce or separate maintenance, (ii) who are separated under a written separation agreement, (iii) who lived apart at all times during the last six months of the year, (iv) where the child receives over one-half of his or her support during the calendar year from both parents, and (v) where such child is in the custody of one or both parents for more than one-half of the year, such child will be considered the dependent of both parents for purposes of the Health Care FSA, regardless of the child's place of residence.

Eligible Expenses. Sample health care expenses include, but are not limited to:

- Deductibles and co-payments;
- Medical, dental and vision expenses not covered by any insurance;
- Prescription drug expenses not covered by any insurance;
- Over-the-counter prescription medicines and drugs if you receive a prescription from your doctor;
- Ambulance fees;
- Chiropractic services;
- Orthodontia;
- Oral contraceptives;
- Contact lenses;
- Hearing aids;
- Certain infertility services;
- Wheelchairs;
- Smoking cessation programs (including nicotine gum and patches);
- Weight loss programs (where there is a diagnosis of a particular medical condition);
- Prosthetics; and
- Durable medical equipment.

Ineligible Expenses. In general, any expenses that cannot be claimed as medical expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to the following:

- Premiums for health insurance;
- Diapers or diaper service;
- Non-prescription items (such as dietary supplements, vitamins and herbal remedies) that are merely beneficial for your or your dependent's general health;
- Certain long-term care expenses;
- Cosmetic surgery (except in limited circumstances);
- Electrolysis;
- Health club dues not related to a specific medical condition;
- Dental bonding and bleaching;
- Services for which any insurance reimburses you; and
- Services rendered before you become a participant in the Plan and after your participation has ended.

Refer to IRS Publication 502, “Medical and Dental Expenses,” for more information regarding eligible and ineligible medical expenses.

Privacy and Security of Health Information. The receipt, use and disclosure of protected health information, as well as the security of protected health information transmitted electronically, is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as “HIPAA”). In accordance with these regulations, the Plan Administrator, certain employees working with, and on behalf of, the Plan and the Plan’s business associates may receive, use and disclose protected health information in order to carry out the payment, treatment and health care operations under of the Plan. These entities and individuals may use protected health information for such purposes without your authorization. If your protected health information is used or disclosed for any other purpose (other than as specifically required or authorized under HIPAA), the Plan must first obtain your written authorization for such use or disclosure. Refer to Appendix A and the Plan’s Privacy Notice for more information on medical records privacy. The Privacy Notice is available on DUCOM’s Web site or from the Human Resources Department.

Qualified Reservist Distributions. The Heroes Earnings Assistance and Relief Tax Act of 2008 (“HEART Act”) permits certain military reservists who are called to active duty to withdraw the unused portion of their Health Care FSAs. Distribution of all or a portion of a military reservist’s account will be allowed if: (i) the individual is a reservist who is ordered to active duty for more than 179 days (or for an indefinite period), and (ii) the distribution is made on or after the date of the order but no later than the last date (March 31) a reimbursement could otherwise be made under the Health Care FSA for the Plan Year containing the date of the order.

Dependent Care FSA: The Dependent Care FSA is designed to help you (1) pay for child care services for a child under age 13 or a child physically or mentally incapable of self-care who resides in your household for more than one-half of the year (provided the child does not provide more than one-half of his or her own support for the year) and does not file a joint tax return (other than only for claim of refund) with his or her spouse for the year, or (2) pay for dependent care services for a disabled spouse who resides in your household for more than one-half of the year or other “Qualifying Relative” (as defined below). This program does not provide health care benefits for dependents. To be eligible, the services must make it possible for you and your spouse to work or to attend school on a full-time basis. Any type of dependent care that you could legally claim if you were filing for credit on your income taxes is eligible for funding under the Dependent Care FSA. Expenses must be incurred prior to the termination of the Plan Year.

Under the Dependent Care FSA rules, only the parent who has custody of the child can treat the child as a dependent, regardless of which parent claims the child as a dependent on his or her tax return. If the parents have joint custody, the parent with whom the child lives for the larger part of the year can treat the child as a dependent for purposes of the Dependent Care FSA.

Please note that you cannot be reimbursed for expenses incurred for an individual who does not meet the definition of a “Qualifying Relative.” An individual is a “Qualifying Relative” if he or she meets the following requirements:

- The individual is a member of your household, and has his or her principal place of residence in your home for more than one-half of the year;
- You furnish over half of the individual's support for the year. In making this calculation, the amount you contribute towards such support must be compared with the amounts received for support by such individual from all other sources, including any amounts supplied by him or her and included in earnings; and
- The individual cannot be claimed by another taxpayer as a dependent child for federal income tax purposes.

To be eligible to use this account, you must be actively working during the time your eligible dependent(s) is (are) receiving care.

Qualifications for Dependent Care FSA. You qualify to use this account if:

- You are a single parent;
- You have a working spouse;
- Your spouse is a full-time student for at least five (5) months during the year you are working; or
- Your spouse is disabled and unable to provide for his or her own care.

Eligible Expenses. Expenses may be reimbursed for services provided:

- Inside or outside your home by anyone other than:
 - > Your spouse
 - > Someone who is your dependent for income tax purposes, or
 - > One of your children under the age of 19.
- In a dependent care center or a child-care center must comply with all applicable state or local regulations); or
- By a housekeeper whose services include, in part, providing care for an eligible dependent.
- At a preschool (up to first grade).
- At a summer day camp.
- By an after-school care center.

To make sure your situation and the type of care being provided meets IRS requirements, refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses." In addition, you should know that if you use a dependent care provider inside your home, you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications should be available on the IRS website (www.irs.gov) and also should be available at your local post office or public library.

Ineligible Expenses. In general, any expenses that cannot be claimed as dependent care expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to the following:

- Non-employment related care, such as babysitting fees during non-working hours or expenses incurred on days when you (or your spouse) are not working due to vacation or illness; provided, however, that care provided during certain “short” or “temporary” absences for illness or vacation may be eligible if you are required to pay for such care on a weekly or longer basis.
- Overnight camp;
- Activity fees;
- School transportation (other than transportation costs that are incurred by a dependent care provider);
- Schooling in the first grade and beyond;
- Pre-first grade schooling that can be separated from the cost of care; and
- Food or clothing.

Maximum Tax-Free Reimbursement. Generally, amounts reimbursed from your Dependent Care FSA are tax-free to you. However, federal law provides that the amount excluded from your gross income cannot exceed the lesser of:

- \$5,000 (\$2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse’s annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse’s actual taxable income (if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either \$250 (if you claim expenses for one dependent) or \$500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse’s annual income is the greater of the actual earned income or these assumed monthly income amounts of either \$250 or \$500. By making an election under the Plan to contribute to a Dependent Care FSA, you are representing to DUCOM that your contributions to your FSA are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the \$2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent’s primary residence for more than six (6) months during the year and you paid more than half of the expenses of that household.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that

individual's social security number. Your care provider should be made aware of this reporting requirement.

Federal Dependent Care Tax Credit. Dependent care expenses for which you are reimbursed from your Dependent Care FSA will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Internal Revenue Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the Dependent Care FSA. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your spouse's earned income.

Therefore, you must determine whether it is more advantageous for you not to establish a Dependent Care FSA in order to avail yourself of the federal tax credit.

As a general rule, depending upon your particular situation, paying for qualifying dependent care expenses through payroll deduction under the Dependent Care FSA will produce greater tax savings the higher your income level. ***If you are not certain as to what extent, if any, it is to your advantage to participate in the Plan, you should consult your personal tax advisor.***

Federal Earned Income Credit. Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for-dollar the federal tax you have to pay, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the Dependent Care FSA for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the Dependent Care FSA may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

Other Tax Credits. You may also be eligible for the Child Tax Credit (CTC), and the Additional Child Tax Credit (ACTC). Consult your personal tax advisor for more information.

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How to File for Reimbursement from the FSAs. When you want to be reimbursed for expenses, you must submit the appropriate claim forms and supporting documentation to the Third Party Administrator. These forms are available on the Third Party Administrator's Web site and must be accompanied by copies of bills, invoices, receipts, canceled checks or other statements showing the amount of such expenses, together with any additional documentation that the Third Party Administrator may request. Claims are paid as soon as administratively possible. An incomplete claim form can increase the amount of time required to send you your reimbursement check.

Expenses under the Health Care FSA will be reimbursed in full up to the amount of your yearly election, less any claim amounts previously reimbursed. Expenses under the Dependent Care FSA will be reimbursed up to your current account balance.

CLAIMS PROCEDURE

Health Care FSAs

After a claim has been filed, as discussed above, the Third Party Administrator shall act within 30 days after its receipt and shall notify the claimant in writing if the claim is denied in whole or in part. If the Third Party Administrator determines that an extension is necessary, a written notice of extension stating the reason therefor and the date by which the Plan expects to render a decision shall be furnished to the claimant before the end of the initial 30-day period. In no event shall such extension exceed 15 days. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If the Third Party Administrator denies your claim for benefits, in whole or in part, you will receive a written notice setting forth:

- specific references to the pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary to perfect the claim and an explanation as to why such information is necessary;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, the Third Party Administrator will state that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and either provide a copy of it with the denial or state that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
- a description of the Plan's review procedure and the time limits applicable for such procedures.

Within 180 days after receipt of the notice described above, a claimant or his or her duly authorized representative shall have an opportunity to appeal the claim denial to the Third Party Administrator for a full and fair review. The claimant or his or her duly authorized representative may:

- request a review upon written notice to the Third Party Administrator;
- examine the Plan and obtain, upon request and without charge, copies of all information relevant to the claimant's appeal; and
- submit issues and comments in writing.

A decision on the review by the Third Party Administrator will be made not later than 60 days after receipt of a request for review. The decision of the Third Party Administrator shall be in writing and shall set forth:

- specific references to the pertinent Plan provisions on which the denial is based;
- a description of any additional material or information necessary to perfect the claim and an explanation as to why such information is necessary;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, the Third Party Administrator will state that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and either provide a copy of it with the denial or state that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; and
- a description of the Plan's review procedure and the time limits applicable for such procedures.

If you, your dependent, your beneficiary, or another interested person challenges the decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue a claim in federal court. Facts and evidence that become known to you, your dependent, your beneficiary, or another interested person after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the initial appeal will be deemed waived.

Dependent Care FSAs

Your Dependent Care FSA is not subject to the claims procedures under the Employee Retirement Income Security Act of 1974 ("ERISA"). Contact the Third Party Administrator for claims information and procedures.

CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federal law that has several provisions designed to protect you and your family against a sudden loss of healthcare coverage if you have a *qualifying event* (explained below) that would cause the loss of your health care coverage provided by DUCOM. The following information outlines the continuation of coverage available under COBRA for your Health Care FSA only. Dependent Care FSA coverage cannot be continued under COBRA.

Explanation of COBRA Continuation Coverage:

COBRA requires most employers who sponsor group health care plans to provide a temporary extension of health care coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called COBRA continuation coverage.

Individuals who are eligible for COBRA coverage are called *qualified beneficiaries*. The events which entitle them to coverage are called qualifying events. In general, to be a qualified beneficiary for a specific type of health coverage (*i.e.*, Health Care FSA), you must have had that particular coverage under the Plan on the day before a qualifying event occurs. However, a child

born to, adopted by, or placed for adoption with the covered employee during the continuation coverage will be a qualified beneficiary for COBRA purposes.

Who Must Provide Notice When Coverage is Lost:

When a qualifying event occurs, you and DUCOM have certain responsibilities. If the qualifying event is divorce or a legal separation, or loss of dependent status, you or a covered family member must notify the Plan Administrator in writing within 60 days of the qualifying event. DUCOM will notify the Plan Administrator if the event is death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

When the Plan Administrator is notified of a qualifying event, the Plan Administrator will send you and/or your dependent(s) a written explanation of the right to elect continuation coverage. You then have 60 days from the latter of the date of this explanation from the Plan Administrator or the date on which your existing coverage would end to notify the Plan Administrator of your election. If you and/or a dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost.

If You Elect to Continue Coverage:

Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one member of the family may make an election that covers some or all of the others.

If you elect to continue coverage, you must pay a total premium equal to the cost to the Plan of such coverage, plus a two percent (2%) monthly administration charge (or such higher charge as may be permitted by law). The total premium includes DUCOM's contribution and any contribution an active participant is required to make under the Plan.

The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your election. Premiums for each month after your election are due by the 1st day of the month and must be paid not later than the last day of that month.

Premium rates will change periodically for all qualified beneficiaries if costs to DUCOM change.

Continuation coverage will be identical to the coverage provided similarly-situated employees and/or dependents. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

Coverage You May Elect:

You may elect to continue Health Care FSA coverage. However, you may elect to continue this coverage only if it was in effect on the date of the qualifying event. Since the Dependent Care FSA is not a health care benefit protected by COBRA, you may not elect continuation coverage of this benefit under the Plan.

If you elect to continue Health Care FSA coverage, you will continue to make contributions to your account on an after-tax basis. If you elect to continue Health Care FSA coverage, you may be reimbursed for eligible medical expenses that are incurred both before the qualifying event and while your continuation coverage is in effect. If you decline to continue Health Care FSA coverage, you will only be reimbursed for eligible medical expenses that were incurred before the qualifying event.

Coverage under Health Care FSA will not continue beyond the Plan Year in which the qualifying event occurs.

Continuation Coverage During Military Service:

Employees and dependents who lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 may elect to continue coverage for up to 24 months, subject to the rules applicable to Health Care FSAs.

PLAN ADMINISTRATOR

The Plan Administrator is DUCOM. In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law.

PLAN AMENDMENT OR TERMINATION

DUCOM reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their dependents. DUCOM also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination, or partial termination.

ADDITIONAL INFORMATION

Plan Sponsor Information:

The sponsor of the Plan is DUCOM. The address and telephone number as well as the employer identification number assigned to DUCOM by the Internal Revenue Service are as follows:

Address: 3201 Arch Street, Suite 430
Philadelphia, PA 19104-2762
Telephone: 215-895-2850
Employer ID #: 23-2979433

Plan Information:

The official Plan name, Plan identification number, and Plan Year (fiscal year used for plan records) for the Plan are as follows:

Plan Name: Drexel University College of Medicine Cafeteria Plan and Summary Plan Description
Plan Year: Begins on January 1 and ends on December 31.

Type of Plan:

The Plan is a welfare benefit plan providing the following types of benefits: (a) health care FSA, and (b) dependent care FSA. The benefit described in item (b) is a “group health plan” within the meaning of ERISA. The Plan also allows for certain medical insurance premiums (medical, prescription drug, dental and vision) to be paid on pre-tax basis.

Administration:

Benefits under the Plan are administered by a Third Party Administrator. Currently, the third party administrator is Y.S.A. (Aon Hewitt), P.O. Box 785040, Orlando, Florida 32878-5040; telephone number: 888-971-0101.

Agent for Legal Process:

The agent for the service of legal process for the Plan is DUCOM at the address set forth above.

Funding Medium:

The benefits under the Plan are funded through direct payments from the general funds of the Plan Sponsor.

NONDISCRIMINATION

Contributions and benefits under the Plan will not discriminate in favor of “Highly Compensated Employees” or “Key Employees.” DUCOM may limit or deny your compensation reduction agreement to the extent necessary to avoid such discrimination with or without your consent.

STATEMENT OF ERISA RIGHTS

IMPORTANT: The following only applies to the Health Care FSA.

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- 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 insurance contracts and 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 and available at the Public Disclosure Room of the Employee Benefits Security Administration. Note that this Plan is included as part of the Drexel University College of Medicine Health and Welfare Plan’s Form 5500 filing, which is filed under the “Drexel University College of Medicine Welfare Program.”
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and updated summary plan description. DUCOM may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If it should happen that the plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Philadelphia Health & Education Corporation d/b/a Drexel University College of Medicine herewith causes this Plan to be executed on the ____ day of _____, 2011 by its duly authorized officer.

**PHILADELPHIA HEALTH & EDUCATION
CORPORATION d/b/a DREXEL UNIVERSITY
COLLEGE OF MEDICINE**

Authorized Officer

Title

APPENDIX A

HIPAA PRIVACY AND SECURITY AND PROTECTED HEALTH INFORMATION

IMPORTANT: The following only applies to the Health Care FSA.
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The following provisions permit the Plan to disclose your protected health information (“PHI”), as defined in HIPAA, to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan. This Appendix A is effective April 14, 2003, and has been amended so as to comply with the Security Rule (as set forth in the final security regulations effective April 20, 2005) and the Health Information for Economic and Clinical Health Act, enacted as part of the American Recovery and Reinvestment Act of 2009 (“ARRA”).

Disclosure To The Plan Sponsor: The Plan (or health insurance issuer or HMO with the Plan’s permission) may disclose your PHI to the Plan Sponsor that is necessary for the Plan Sponsor to carry out the following administrative functions related to the Plan.

The Plan Sponsor needs access to PHI to:

- Determine whether you and/or your dependent are eligible for benefits under the Plan;
- Determine the amount of benefits, if any, you and/or your dependent are entitled to from the Plan;
- Determine or find facts that are relevant to any claim for benefits from the Plan;
- Determine whether a participant’s benefits should be terminated or suspended;
- Perform duties relating to the establishment, maintenance and administration of the Plan;
- Communicate with participants regarding the status of their claims;
- Recover any overpayment or mistaken payments made to claimants; and
- Handle participant issues with regard to subrogation and third party claims.

The Plan Sponsor may use and disclose your PHI provided to it from the Plan (or health insurance issuer or HMO) only for the administrative purposes described above.

Limitations And Requirements Related To The Use and Disclosure of PHI: The Plan Sponsor agrees to the following limitations and requirements related to its use and disclosure of your PHI received from the Plan:

- (a) Use and Further Disclosure. The Plan Sponsor will not use or further disclose your PHI other than as permitted or required by this document or as required by law. When using or disclosing your PHI or when requesting your PHI from the Plan, the Plan Sponsor will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.
- (b) Agents and Subcontractors. The Plan Sponsor will require any agents, including subcontractors, to whom it provides your PHI received from the Plan to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

- (c) Employment-Related Actions and Decisions. Except as permitted by HIPAA and other applicable law, the Plan Sponsor will not use your PHI to take employment-related actions or make employment-related decisions about you, or in connection with any other employee benefit plan of the Plan Sponsor.
- (d) Reporting of Improper Use or Disclosure. The Plan Sponsor will promptly report to the Plan any improper use or disclosure of your PHI of which it becomes aware.
- (e) Adequate Protection. The Plan Sponsor will provide adequate protection of PHI and separation between the Plan and the Plan Sponsor by:
 - (1) ensuring that only the minimum necessary number of benefits representatives in DUCOM's Human Resources Department will have access to your PHI provided by the Plan;
 - (2) restricting access to and use of your PHI to only the employees identified above and only for the administrative functions performed by the Plan Sponsor on behalf of the Plan that are described above;
 - (3) requiring any agents of the Plan who receive your PHI to abide by the Plan's privacy rules; and
 - (4) using the following procedure to resolve issues of noncompliance by the employees identified above:
 - (a) The Plan will be immediately notified, and the Plan and Plan Sponsor will work together to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI;
 - (b) After an investigation into the alleged incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate; and
 - (c) The Plan and Plan Sponsor will work together to create new safeguards and procedures so as to prevent a future incident of noncompliance.
- (f) Breach of Unsecured PHI. Upon the discovery of a potential breach of PHI, the Plan Sponsor will determine whether the incident is an actual breach under ARRA, and comply with the timing, content and other breach notification requirements of ARRA. The Plan Sponsor will take appropriate measures to mitigate any harm that has resulted or may result from the breach and to prevent such a breach from occurring in the future.
- (g) Electronic PHI. The Plan Sponsor will take appropriate measures to maintain the confidentiality, integrity and availability of PHI that is stored or transmitted electronically ("Electronic PHI") by:

- (a) implementing administrative, physical, and technical safeguards for Electronic PHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;
- (b) ensuring that the adequate separation between the Plan and the Plan Sponsor described in paragraph (d) is supported by reasonable and appropriate security measures;
- (c) requiring any agents of the Plan who receive your Electronic PHI to abide by the Plan's security rules; and
- (d) reporting to the Plan any security incident of which it becomes aware.

Employment records and Plan enrollment information are not considered electronic PHI.

- (h) Return or Destruction of PHI. If feasible, the Plan Sponsor will return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- (i) Participant Rights. The Plan Sponsor will provide you with the following rights:
 - (1) the right to access to your PHI;
 - (2) the right to amend your PHI upon request (or the Plan Sponsor will explain to you in writing why the requested amendment was denied) and incorporate any such amendment into your PHI; and
 - (3) the right to an accounting of all disclosures of your PHI.
- (j) Cooperation with HHS. The Plan Sponsor will make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for verification of the Plan's compliance with HIPAA.

Certification: The Plan will disclose PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that this Plan document has been amended in accordance with HIPAA, and that the Plan Sponsor will protect the PHI as described above.