

***TRINITY UNIVERSITY***  
***HEALTH CARE REIMBURSEMENT PLAN***

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# TRINITY UNIVERSITY HEALTH CARE REIMBURSEMENT PLAN

## INTRODUCTION

The Employer has amended the Trinity University Flexible Benefits Plan effective April 14, 2004, to recognize the contribution made to the Employer by its Employees. Its purpose is to reward them by providing benefits for those Employees who shall qualify hereunder and their dependents and beneficiaries. This Health Care Reimbursement Plan is a separate restatement of the health care reimbursement program that was stated as part of the prior Trinity University Flexible Benefits Plan, originally effective on June 1, 1987 and previously amended on June 1, 2001. This separately stated Plan shall be known as the Trinity University Health Care Reimbursement Plan (the "Plan") and is incorporated by reference into the Trinity Flexible Benefits Plan.

The intention of the Employer is that the Trinity Flexible Benefits Plan qualify as a "Cafeteria Plan" within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended, and that the benefits which an Employee elects to receive under this Health Care Reimbursement Plan be includible or excludable from the Employee's income under Section 125(a) and other applicable sections of the Internal Revenue Code of 1986, as amended, in coordination with the Trinity Flexible Benefit Plan.

## **Article I.** **DEFINITIONS**

1.1 Administrator. Administrator means the individuals or corporation appointed by the Employer to carry out the administration of the Plan. In the event the Administrator has not been appointed, or resigns from a prior appointment, the Employer shall be deemed to be the Administrator.

1.2 Affiliated Employer. Affiliated Employer means the Employer and any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

1.3 Benefit. Benefit means any of the optional benefit choices available to a Participant as outlined in Article IV.

1.4 Cafeteria Plan Benefit Dollars. Cafeteria Plan Benefit Dollars means the amount available to Participants, pursuant to Article III, to purchase Benefits. Each dollar contributed to this Plan shall be converted into one Cafeteria Plan Benefit Dollar.

1.5 Code. Code means the Internal Revenue Code of 1986, as amended or replaced from time to time.

1.6 Compensation. Compensation means the total cash remuneration received by the Participant from the Employer during a Plan Year. Compensation shall include overtime, commissions and bonuses.

1.7 Dependent. Dependent means any individual who qualifies as a dependent under an Insurance Contract or under Code Section 152 (as modified by Code Section 105(b)).

1.8 Effective Date. Effective Date means April 14, 2004:

1.9 Election Period. Election Period means an Employee's initial Election Period as determined pursuant to Section 5.1.

1.10 Eligible Employee. Eligible Employee means any Employee whose customary employment, excluding overtime work, is considered to be at least one-half of full time, as such is determined by the Administrator and who has satisfied the provisions of Section 2.1. Faculty members, however, must be full-time faculty in order to be an Eligible Employee.

1.11 Employee. Employee means any person who is employed by the Employer, but excludes any person who is employed as an independent contractor. The term Employee shall include leased employees within the meaning of Code Section 414(n)(2).

1.12 Employer. Employer means Trinity University and any successor which shall maintain this Plan; and any predecessor which has maintained this Plan.

1.13 Employer Contribution. Employer Contribution means the contributions made by the Employer pursuant to Section 3.1 to enable a Participant to purchase Benefits. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.14 ERISA. ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.15 Insurance Contract. Insurance Contract means any contract issued by an Insurer underwriting a Benefit.

1.16 Insurer. Insurer means any insurance company that underwrites a Benefit under this Plan or, with respect to any self-funded benefits, the Employer.

1.17 Key Employee. Key Employee means an Employee described in Code Section 416(i)(1) and the Treasury regulations thereunder.

1.18 Participant. Participant means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.19 Plan. Plan means this instrument, including all amendments thereto.

1.20 Plan Year. Plan Year means the 12-month period beginning June 1st and ending May 31st. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on such Participant's date of entry and ending on the last day of such Plan Year.

1.21 Premium Expenses or Premiums. Premium Expenses or Premiums mean the Participant's cost for the self-funded Benefits described in Section 4.1.

1.22 Premium Reimbursement Account. Premium Reimbursement Account means the account established for a Participant pursuant to this Plan to which part of his Cafeteria Plan Benefit Dollars may be allocated and from which Premiums of the Participant may be paid or reimbursed. If more than one type of insured or self-funded Benefit is elected, sub-accounts shall be established for each type of insured or self-funded Benefit.

1.23 Salary Redirection. Salary Redirection means the contributions made by the Employer on behalf of Participants pursuant to Section 3.2. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

1.24 Salary Redirection Agreement. Salary Redirection Agreement means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation or to forego all or part of the increases in such Compensation and to have such amounts contributed by the Employer to the Plan on the Participant's behalf. The Salary Redirection Agreement shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and, subsequently does not become currently available to the Participant.

1.25 Spouse. Spouse means the legally married husband or wife of a Participant, unless legally separated by court decree.

## **Article II.** **PARTICIPATION**

2.1 Eligibility.

Any Eligible Employee shall be eligible to participate hereunder as of his or her date of employment (or the Effective Date of the Plan, if later). However, any Eligible

Employee who was a Participant in the Plan on the effective date of this amendment shall continue to be eligible to participate in the Plan.

2.2 Effective Date of Participation.

An Eligible Employee shall become a Participant effective as of the date on which he or she satisfies the requirements of Section 2.1.

2.3 Application to Participate.

An Employee who is eligible to participate in this Plan shall, during the applicable Election Period, complete an application to participate and election of benefits form which the Administrator shall furnish to the Employee. The election made on such form shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.3 hereof.

An Eligible Employee shall also be required to execute a Salary Redirection Agreement during the Election Period for the Plan Year during which he or she wishes to participate in this Plan. Any such Salary Redirection Agreement shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.2.

2.4 Termination of Participation.

A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

- A. His or her termination of employment, subject to the provisions of Section 2.6;
- B. The end of the Plan Year during which he or she became a limited Participant because of a change in employment status pursuant to Section 2.5;
- C. His or her death, subject to the provisions of Section 2.7; or
- D. The termination of this Plan, subject to the provisions of Section 9.2.

2.5 Change of Employment Status.

If a Participant ceases to be eligible to participate because of a change in employment status or classification (other than through termination of employment), the Participant shall become a limited Participant in this Plan for the remainder of the Plan Year in which such change of employment status occurs. As a limited Participant, no further Salary Redirection may be made on behalf of the Participant, and, except as otherwise provided herein, all further Benefit elections shall cease. Subject to the provisions of Section 2.6, if the limited Participant later becomes an Eligible Employee,

then the limited Participant may again become a full Participant in this Plan, provided he or she otherwise satisfies the participation requirements set forth in this Article II as if he or she were a new Employee and made an election in accordance with Section 5.1.

2.6 Termination of Employment.

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Plan shall be governed in accordance with the following:

A. The Participant's participation in the Plan shall cease and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for expenses incurred during the portion of the Plan Year preceding his date of termination.

B. In the event a Participant terminates his participation in the Health Care Reimbursement Plan during the Plan Year, if Salary Redirections are made other than on a pro rata basis, upon termination the Participant shall be entitled to a reimbursement for any Salary Redirection previously paid for coverage or benefits relating to the period after the date of the Participant's separation from service regardless of the Participant's claims or reimbursements as of such date.

C. This Section shall be applied and administered consistent with such further rights a Participant and his Dependents may be entitled to pursuant to Code Section 4980B and Section 11.13 of the Plan.

2.7 Death.

If a Participant dies, his or her participation in the Plan shall cease. However, such Participant's beneficiaries, or the representative of his or her estate, may submit claims for expenses or benefits for the remainder of the Plan Year or until the Cafeteria Plan Benefit Dollars allocated to each specific benefit are exhausted. A Participant may designate a specific beneficiary for this purpose. If no such beneficiary is specified, the Administrator may designate the Participant's Spouse, one of his or her Dependents or a representative of his or her estate.

**Article III.**  
**CONTRIBUTIONS TO THE PLAN**

3.1 Employer Contribution.

The Employer shall make available to each Participant an Employer Contribution in an amount to be determined by the Employer prior to the beginning of each Plan Year. Each Participant's Employer Contribution shall be converted to Cafeteria Plan Benefit Dollars and be available to purchase Benefits pursuant to Article IV. The Employer's

Contribution shall be made on a pro rata basis for each pay period of the Participant. If no Benefits are selected, there shall be no Employer Contribution.

### 3.2 Salary Redirection.

If a Participant's Employer Contribution is not sufficient to cover the cost of Benefits or Premium Expenses he or she elects pursuant to Article IV, his or her Compensation will be reduced in an amount equal to the difference between the cost of Benefits he or she elected and the amount of Employer Contribution available to him or her. Such reduction shall be his or her Salary Redirection, which the Employer will use on his or her behalf, together with his or her Employer Contribution, to pay for the Benefits he or she elected. The amount of such Salary Redirection shall be specified in the Salary Redirection Agreement and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Salary Redirection Agreement shall only be applicable from the last day of the pay period following the Employee's entry date up to and including the last day of the Plan Year. These contributions shall be converted to Cafeteria Plan Benefit Dollars and allocated to the funds or accounts established under the Plan pursuant to the Participants' elections made under Article V.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or a Salary Redirection Agreement after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Department of the Treasury. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year. All individual Salary Redirection Agreements are deemed to be part of this Plan and incorporated by reference hereunder.

### 3.3 Application of Contributions.

As soon as reasonably practical after each payroll period, the Employer shall apply the Employer Contribution, if any, and Salary Redirection to provide the Benefits elected by the affected Participants. Any contribution made or withheld shall be credited to such fund or account.

### 3.4 Periodic Contributions.

Notwithstanding the requirement provided above and in other Articles of this Plan that Salary Redirections be contributed to the Plan by the Employer on behalf of an Employee on a level and pro rata basis for each payroll period, the Employer and Administrator may implement a procedure in which Salary Redirections are contributed throughout the Plan Year on a periodic basis that is not pro rata for each payroll period. However, the payment schedule for the required contributions may not be based on the rate or amount of reimbursements during the Plan Year. In the event Salary Redirections

are not made on a pro rata basis, upon termination of participation, a Participant may be entitled to a refund of such Salary Redirections pursuant to Section 2.6.

**Article IV.**  
**HEALTH CARE REIMBURSEMENT PLAN BENEFIT**

4.1 Establishment of Plan.

This Health Care Reimbursement Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Care Reimbursement Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed under this Health Care Reimbursement Plan shall be periodically paid from amounts allocated to the Health Care Reimbursement Fund. Periodic payments reimbursing Participants from the Health Care Reimbursement Fund shall in no event occur less frequently than monthly.

4.2 Definitions.

For the purposes of this Article and the Cafeteria Plan, the terms below have the following meaning:

A. “Health Care Reimbursement Fund” means the fund established for Participants pursuant to this Plan to which part of their Cafeteria Plan Benefit Dollars may be allocated and from which all allowable Medical Expenses may be reimbursed.

B. “Health Care Reimbursement Plan” means the plan of benefits contained in this Article, which provides for the reimbursement of eligible Medical Expenses incurred by a Participant or his Dependents.

C. “Highly Compensated Participant” means, for the purposes of this Article and determining discrimination under Code Section 105(h), a participant who is:

1. one of the 5 highest paid officers;
2. a shareholder who owns (or is considered to own applying the rules of Code Section 318) more than 10 percent in value of the stock of the Employer; or
3. among the highest paid 25 percent of all Employees (other than exclusions permitted by Code Section 105(h)(3)(B) for those individuals who are not Participants j.

D. “Medical Expenses” means any expense for medical care within the meaning of the term “medical care” or “medical expense” as defined in Code Section 213 and the rulings and Treasury regulations thereunder, and

not otherwise used by the Participant as a deduction in determining his tax liability under the Code. However, a Participant may not be reimbursed for the cost of other health coverage such as premiums paid under plans maintained by the employer of the Participant's spouse or individual policies maintained by the Participant or his spouse or Dependent. Furthermore, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

E. The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Care Reimbursement Plan.

#### 4.3 Forfeitures.

The amount in the Health Care Reimbursement Fund as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6.7 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

#### 4.4 Limitation on Allocations.

Notwithstanding any provision contained in this Health Care Reimbursement Plan to the contrary, no more than \$5,000 may be allocated to the Health Care Reimbursement Fund by a Participant in or on account of any Plan Year.

#### 4.5 Cash Benefit.

If a Participant does not elect any Salary Redirections, such Participant shall be deemed to have chosen the Cash Benefit as his or her sole Benefit Option. However, if a Participant fails to make any election of Benefit Option, then the Employer Contribution will be deemed to be waived.

#### 4.6 Nondiscrimination Requirements.

A. It is the intent of this Health Care Reimbursement Plan not to discriminate in violation of the Code and the Treasury regulations thereunder.

B. If the Administrator deems it necessary to avoid discrimination under this Health Care Reimbursement Plan, it may, but shall not be required to, reject any elections or reduce contributions or Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any elections or reduce contributions or Benefits, it shall be done in the following manner. First, the Benefits designated for the Health Care Reimbursement Fund by the member of the group in whose favor

discrimination may not occur pursuant to Code Section 105 that elected to contribute the highest amount to the fund for the Plan Year shall be reduced until the nondiscrimination tests set forth in this Section or the Code are satisfied, or until the amount designated for the fund equals the amount designated for the fund by the next member of the group in whose favor discrimination may not occur pursuant to Code Section 105 who has elected the second highest contribution to the Health Care Reimbursement Fund for the Plan Year. This process shall continue until the nondiscrimination tests set forth in this Section or the Code are satisfied. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and credited to the benefit plan surplus.

C. It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

D. It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Section 125.

E. It is the intent of this Plan not to provide qualified benefits as defined under Code Section 125 to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan. For purposes of the preceding sentence, qualified benefits shall not include benefits which (without regard to this paragraph) are includible in gross income.

F. If the Administrator deems it necessary to avoid discrimination or possible taxation to Key Employees or a group of employees in whose favor discrimination may occur in violation of Code Section 125, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. If the Administrator decides to reject any election or reduce contributions or non-taxable Benefits, it shall be done in the following manner. First, the non-taxable Benefits of the affected Participant (either an employee who is highly compensated or a Key Employee, whichever is applicable) who has the highest amount of non-taxable Benefits for the Plan Year shall have his non-taxable benefits reduced until the discrimination tests set forth in this Section are satisfied or until the amount of his non-taxable Benefits equals the non-taxable Benefits of the affected Participant who has the second highest amount of non-taxable Benefits. This process shall continue until the nondiscrimination tests set forth in this Section are satisfied. With respect

to any affected Participant who has had Benefits reduced pursuant to this Section, the reduction shall be made proportionately among the benefits offered. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

4.7 Coordination with Cafeteria Plan.

All Participants under the Cafeteria Plan are eligible to receive Benefits under this Health Care Reimbursement Plan. The enrollment under the Cafeteria Plan shall constitute enrollment under this Health Care Reimbursement Plan. In addition, other matters concerning contributions, elections and the like shall be governed by the general provisions of the Cafeteria Plan.

4.8 Health Care Reimbursement Plan Claims.

A. All Medical Expenses incurred by a Participant shall be reimbursed during the Plan Year subject to Section 2.6, even though the submission of such a claim occurs after his participation hereunder ceases; but provided that the Medical Expenses were incurred during the applicable Plan Year. Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for the medical care.

B. The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount designated by the Participant for the Health Care Reimbursement Fund for the Plan Year. Reimbursements shall be made available to the Participant throughout the year without regard to the level of Cafeteria Plan Benefit Dollars which have been allocated to the fund at any given point in time. Furthermore, a Participant shall be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

C. Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim within the 60 day period immediately following the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator.

D. Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form

within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage and, if reimbursed from the Health Care Reimbursement Fund, such amount will not be claimed as a tax deduction. The Administrator shall retain a file of all such applications.

**Article V.**  
**PARTICIPANT ELECTIONS**

5.1 Initial Elections.

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he or she elects to do so before his or her effective date of participation pursuant to Section 2.2. However, if such Employee does not complete an application to participate and benefit election form and deliver it to the Administrator before such date, his or her Election Period shall extend 30 calendar days after such date, or for such further period as the Administrator shall determine and apply on a uniform and nondiscriminatory basis. However, any election during the extended 30-day election period pursuant to this Section 5.1 shall not be effective until the first pay period following the later of such Participant's effective date of participation pursuant to Section 2.2 or the date of the receipt of the election form by the Administrator, and shall be limited to the Benefit expenses incurred for the balance of the Plan Year for which the election is made.

5.2 Failure to Elect.

Any Participant failing to complete an election of benefits form pursuant to Section 5.1 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan. No further Salary Redirections shall therefore be authorized for any subsequent Plan Year, except as provided in Section 5.3.

5.3 Change of Elections.

A. Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the changes are necessitated by and are consistent with a change in status which is acceptable under rules and regulations adopted by the Department of the Treasury, the provisions of which are hereby incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a spouse, the death of a spouse or dependent, or a dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel accident or health insurance coverage for any individual other than the one involved in such event. In addition, if the Participant, spouse or dependent gains eligibility for coverage under a family member plan as a result of a change in marital status or a change in employment status, then a Participant's election under the Plan to cease or decrease coverage for that individual under the Plan corresponds with that change in status only if coverage for that individual becomes applicable or is increased under the family member plan.

If the change in status is a change in status in the Participant's marital status under (1) below or a change in employment status of the Participant's spouse or covered dependents under (3) below, an election to increase, or an election to decrease, group-term life or disability coverage corresponds with that change in status.

Regardless of the consistency requirement, if the individual, the individual's spouse, or dependent becomes eligible for continuation coverage under the Employer's group health plan as provided in Code Section 4980B or any similar state law, then the individual may elect to increase payments under this Plan in order to pay for the continuation coverage.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by Treasury regulations:

1. Legal Marital Status: events that change a Participant's legal marital status, including marriage, divorce, death of a spouse, legal separation or annulment;
2. Number of Dependents: Events that change a Participant's number of dependents, including birth, adoption, placement for adoption, or death of a dependent;
3. Employment Status: Any of the following events that change the employment status of the Participant, spouse, or dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other

employee benefit plan of the Employer of the Participant, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

4. Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and
5. Residency: A change in the place of residence of the Participant, spouse or dependent.

B. Notwithstanding subsection A., the Participants may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f).

C. Notwithstanding subsection A., in the event of a judgment, decree, or order ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child:

1. The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or
2. The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former spouse to provide coverage for such child.

D. Notwithstanding subsection A., a Participant may change elections to cancel accident or health coverage for the Participant or the Participant's spouse or dependent if the Participant or the Participant's spouse or dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).

E. If the cost of a Benefit provided under the Plan increases or decreases during a Plan Year, then the Plan shall automatically increase or

decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage.

If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage.

If, during the period of coverage, a new benefit package option or other coverage option is added (or an existing benefit package option or other coverage option is eliminated), then the affected Participants may elect the newly-added option (or elect another option if an option has been eliminated) prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage.

A Participant may make a prospective election change that is on account of and corresponds with a change made under the plan of a spouse's, former spouse's or dependent's employer if (1) the cafeteria plan or other benefits plan of the spouse's, former spouse's or dependent's employer permits its participants to make a change; or (2) the cafeteria plan permits participants to make an election for a period of coverage that is different from the period of coverage under the cafeteria plan of a spouse's, former spouse's or dependent's employer.

A Participant shall not be permitted to change an election to the Health Care Reimbursement Plan as a result of a cost or coverage change under this subsection.

## **Article VI.** **CLAIMS PROCEDURE**

### 6.1 Submitting Claims.

Notwithstanding any provisions hereof to the contrary, the following claims procedure provisions shall apply to Claims filed under the Plan on or after January 1, 2003. Written notice and proof of an incurred claim should always be with the Administrator as soon as possible. Claims must be filed within twelve (12) months from the date of service to be covered by the Plan. Claims must be filed sooner in certain circumstances as discussed below. If it can be shown that it was not reasonably possible to submit the notice within this period and that notice was given as soon as possible, the claim will not be reduced or invalidated. If an individual's coverage under the Plan ceases, all claims incurred prior to termination of coverage must be filed within ninety (90) days after the termination of coverage or the claim will not be covered by the Plan. If the Plan is terminated, all claims incurred prior to the Plan termination must be received within ninety

(90) days after the termination or the claims will not be covered. Any claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

#### 6.2 Notice of Failure to Follow Procedures.

In the case of a failure by a Plan Participant or an authorized representative of a Plan Participant to follow the Plan's procedures for filing a pre-service claim, the Plan Participant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the Plan Participant or authorized representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Plan Participant or authorized representative. This section shall apply only in the case of a failure that (i) is a communication by a Plan Participant or an authorized representative of a Plan Participant that is received by a person or organizational unit customarily responsible for handling benefit matters, and (ii) is a communication that names a specific Plan Participant; a specific medical condition or symptom; and a specific treatment, service or product for which approval is requested.

#### 6.3 Timing of Notification of Benefit Determination.

Except as provided below, if a claim is wholly or partially denied, the Administrator shall notify the Plan Participant of the Plan's Adverse Benefit Determination within a reasonable period of time, but not later than ninety (90) days after receipt of the claim by the Plan, unless the Administrator determines that special circumstances require an extension of time for processing the claim. If the Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Plan Participant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

#### 6.4 Calculating Time Periods.

For purposes of this section, the period of time within which a benefit determination is required to be made shall begin at the time a claim is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended as permitted above due to a Plan Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information.

#### 6.5 Manner and Content of Notification of Benefit Determination.

Except as provided below, the Administrator shall provide a Plan Participant with written or electronic notification of any Adverse Benefit Determination. Any electronic

notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). The notification shall set forth, in a manner calculated to be understood by the Plan Participant:

- a. the specific reason or reasons for the adverse determination;
- b. reference to the specific Plan provisions on which the determination is based;
- c. a description of any additional material or information necessary for the Plan Participant to perfect the claim and an explanation of why such material or information is necessary; and
- d. a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Plan Participant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on review.

#### 6.6 Appeal of Adverse Benefit Determination.

A Plan Participant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to the Appeals Administrator, and there will be a full and fair review of the claim and the Adverse Benefit Determination. Any appeal must be filed with the Administrator, who will forward the appeal to the Appeals Administrator. The Plan shall provide a Plan Participant with a reasonable opportunity for a full and fair review of a claim and Adverse Benefit Determination. Plan Participants shall have one hundred eighty (180) days following receipt of a notification of an Adverse Benefit Determination within which to appeal the determination. The review shall not afford deference to the initial Adverse Benefit Determination and shall be conducted by the Appeals Administrator of the Plan, who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.

#### 6.7 Timing of Notification of Benefit Determination on Review.

Except as provided below, the Appeals Administrator shall notify a Plan Participant of the Plan's benefit determination on review within a reasonable period of time, but no later than sixty (60) days after receipt of the Plan Participant's request for review by the Plan, unless the Appeals Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time for processing the claim. If the Appeals Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Plan Participant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the determination on review.

For purposes of this section, the period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Plan Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the Plan Participant until the date on which the Plan Participant responds to the request for additional information.

In the case of an Adverse Benefit Determination on review, the Appeals Administrator shall provide such access to, and copies of, documents, records, and other information described in the paragraph below as is appropriate.

#### 6.8 Manner and Content of Notification of Benefit Determination on Review.

The Appeals Administrator shall provide a Plan Participant with written or electronic notification of a Plan's benefit determination on review. Any electronic notification shall comply with the standards imposed by 29 CFR 2520.104b-1(c)(1)(i), (iii), and (iv). In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the Plan Participant:

1. the specific reason or reasons for the adverse determination;
2. reference to the specific Plan provisions on which the benefit determination is based;
3. a statement that the Plan Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Plan Participant's claim for benefits; and
4. a statement of the Plan Participant's right to bring an action under Section 502(a) of ERISA.

#### 6.9 Preemption of State Law.

Nothing in this Article shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this Article.

#### 6.10 Definitions.

The following terms shall have the following meaning ascribed to such terms whenever such term is used in this Article:

**Adverse Benefit Determination:** any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a

benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Plan Participant's or beneficiary's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

**Appeals Administrator:** the Employer, unless another Fiduciary, other than the Administrator, is designated by the Employer to be the Appeals Administrator of the Plan.

**Claim for Benefits:** a request for a plan benefit or benefits made by a Plan Participant in accordance with the Plan's procedure for filing benefit claims. A claim for benefits includes any pre-service claims and any post-service claims.

**Health Care Professional:** a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

**Notice or Notification:** the delivery or furnishing of information to an individual in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual.

## **Article VII.** **ERISA**

### 7.1 Application of Benefit Plan Surplus.

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall first be used to defray any administrative costs and experience losses and thereafter be retained by the Employer.

### 7.2 Named Fiduciary.

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the Plan.

### 7.3 General Fiduciary Responsibilities.

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to this Plan solely in the interest of the Participants and their beneficiaries and

- A. for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;
- B. with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and
- C. in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

### 7.4 Non-Assignability of Rights.

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

## **Article VIII. ADMINISTRATION**

### 8.1 Plan Administration.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator shall have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code. The Administrator's powers shall include, but shall not be limited to the following authority, in addition to all other powers provided by this Plan:

- A. To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;
- B. To interpret the Plan, the Administrator's interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

C. To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

D. To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

E. To provide Employees with a reasonable notification of their benefits available by operation of the Plan;

F. To approve reimbursement requests and to authorize the payment of benefits; and

G. To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

#### 8.2 Examination of Records.

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

#### 8.3 Payment of Expenses.

Any reasonable administrative expenses shall be paid by the Employer unless the Employer determines that administrative costs shall be borne by the Participants under the Plan or by any Trust Fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

#### 8.4 Insurance Control Clause.

In the event of a conflict between the terms of this Plan and the terms of an Insurance Contract of an independent third party Insurer whose product is then being used in conjunction with this Plan, the terms of the Insurance Contract shall control as to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

8.5 Indemnification of Administrator.

The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

**Article IX.**  
**AMENDMENT OR TERMINATION OF PLAN**

9.1 Amendment.

The Employer, at any time or from time to time, may amend any or all of the provisions of the Plan without the consent of any Employee or Participant. No amendment shall have the effect of modifying any benefit election of any Participant in effect at the time of such amendment, unless such amendment is made to comply with Federal, state or local laws, statutes or regulations.

9.2 Termination.

The Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate this Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions shall be made. Benefits under any Insurance Contract shall be paid in accordance with the terms of the Insurance Contract.

No further additions shall be made to this Health Care Reimbursement Fund but all payments from such fund shall continue to be made according to the elections in effect until the end of the Plan Year in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims). Any amounts remaining in any such fund or account as of the end of the Plan Year in which Plan termination occurs shall be forfeited and deposited in the benefit plan surplus after the expiration of the filing period.

**Article X.**  
**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

10.1 Operation in Accordance with HIPAA and Regulations Thereunder.

Notwithstanding anything in this Plan to the contrary, the Plan shall be operated in accordance with HIPAA and regulations thereunder.

Effective April 14, 2004, the Plan conforms with the requirements of Section 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its

implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the “HIPAA Privacy Rule” and Section 164.504(f) is referred to as “the ‘504’ provisions”) by establishing the extent to which the Employer will receive, use, and/or disclose Protected Health Information (herein referred to as “PHI”).

#### 10.2 Plan’s Designation of Person/Entity to Act on its Behalf.

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates the Employer to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (e.g., entering into business associate contracts and accepting certification from the Employer).

#### 10.3 The Plan’s Disclosure of PHI to the Employer/Required Certification of Compliance by the Employer.

Except as provided below with respect to the Plan’s disclosure of summary health information, the Plan will (i) disclose PHI to the Employer, or (ii) provide for or permit the disclosure of PHI to the Employer by a health insurance insurer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Employer) that:

- (1) the Plan has been amended to establish the permitted and required uses and disclosures of such information by the Employer, consistent with the “504 provisions”;
- (2) the Plan has been amended to incorporate the Plan provisions set forth in this section; and
- (3) the Employer agrees to comply with the Plan provisions as modified by this section.

#### 10.4 Permitted Disclosure of Individuals’ PHI to the Employer.

The Plan (and any business associate acting on behalf of the Plan), or any health insurance issuer or HMO servicing the Plan, will disclose individuals’ PHI to the Employer only to permit the Employer to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the PHI of the Plan’s individuals by the Plan’s business associate, health insurance issuer, or HMO to the Employer will comply with the restrictions and requirements set forth in this section and in the “504 provisions.”

The Plan (and any business associate acting on behalf of the Plan) may not, and may not permit the health insurance issuer or HMO to, disclose individuals’ PHI to the Employer for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer.

The Employer will not use or further disclose individuals' PHI other than as described in the Plan and permitted by the "504 provisions".

The Employer will ensure that any agent(s), including a subcontractor, to whom it provides individuals' PHI received from the Plan (or from the Plan's health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Employer with respect to such PHI.

The Employer will not use or disclose individuals' PHI for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan of the Employer.

The Employer will report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in the Plan (as amended) and in the "504 provisions," of which the Employer becomes aware.

#### 10.5 Disclosure of Individuals' PHI/Disclosure by the Employer

The Employer will make the PHI of the individual who is the subject of the PHI available to such individual in accordance with 45 C.F.R. Section 164.524.

The Employer will make individuals' PHI available for amendment and incorporate any amendments to individuals' PHI in accordance with 45 C.F.R. Section 164.526 for an individual who requests amendment of his or her PHI.

The Employer will make and maintain an accounting so that it can make available those disclosures of individuals' PHI that it must account for in accordance with 45 C.F.R. Section 164.528.

The Employer will make its internal practices, books and records relating to the use and disclosure of individuals' PHI received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Employer will, if feasible, return or destroy all individuals' PHI received from the Plan (or a health insurance issuer or HMO with respect to the to the Plan) that the Employer still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Employer will not retain copies of such PHI after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Employer will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Employer will ensure that adequate separation between the Plan and the Employer is established and maintained as required by the "504 provisions".

#### 10.6 Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Employer.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Employer without the need to amend the Plan as provided for in the “504 provisions,” if the Employer requests the summary health information for the purpose of:

- (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- (2) modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Employer without the need to amend the Plan as provided for in the “504 provisions.”

#### 10.7 Required Separation Between the Plan and the Employer.

In accordance with the “504 provisions,” the following is a description of the employees, classes of employees, or workforce members under the control of the Employer who may be given access to individuals’ PHI received from the Plan or from a health insurance issuer or HMO servicing the Plan:

1. President;
2. Vice Presidents;
3. Director of Human Resources;
4. Assistant Director of Human Resources;
5. Employee and Benefits Administrator;
6. Clerical Staff of Human Resources; and
7. Internal Auditor.

The above list reflects the employees, classes of employees, or other workforce members of the Employer who receive individuals’ PHI relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Employer provides for the Plan. These individuals will have access to individuals’ PHI solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Employer) for any use or disclosure of individuals’ PHI in violation of, or noncompliance with, the provisions of this section.

The Employer will promptly report any such breach, violation, or non-compliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

**Article XI.**  
**MISCELLANEOUS**

11.1 Plan Interpretation.

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 10.11.

11.2 Gender and Number.

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 Written Document.

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 Exclusive Benefit.

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 Participant's Rights.

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

#### 11.6 Action by the Employer.

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

#### 11.7 No Guarantee of Tax Consequences.

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

#### 11.8 Indemnification of Employer by Participants.

If any Participant receives one or more payments or reimbursements under the Plan that are not for a permitted Benefit, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax (plus any penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, plus the Participant's share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the Participant.

#### 11.9 Funding.

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

#### 11.10 Governing Law.

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by federal law, the provisions of this Plan shall be construed, enforced and administered according to the laws of the State of Texas.

11.11 Severability.

If any provision of the Plan is held invalid or unenforceable, its invalidity or unenforceability shall not affect any other provisions of the Plan, and the Plan shall be construed and enforced as if such provision had not been included herein.

11.12 Captions.

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.13 Continuation of Coverage.

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant will be entitled to continuation coverage as prescribed in Code Section 4980B.

11.14 Family and Medical Leave Act.

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Proposed Regulation Section 1.125-3.

11.15 Uniform Services Employment and Reemployment Rights Act.

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with Uniform Services Employment and Reemployment Rights Act and the regulations thereunder.