

**WILLIAM MARSH RICE UNIVERSITY
DEPENDENT CARE
FLEXIBLE SPENDING ACCOUNT PROGRAM**

Effective June 30, 2004

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ARTICLE I
INTRODUCTION

1.1 Amendment and Restatement of Program. The William Marsh Rice University Dependent Care Spending Program was previously established under and made a part of the William Marsh Rice University Flexible Benefits Plan for Faculty and Staff Employees. The William Marsh Rice University Flexible Benefits Plan for Faculty and Staff Employees is merged into and consolidated with the William Marsh Rice University Health and Welfare Benefits Plan (the “Plan”) effective June 30, 2004 and the William Marsh Rice University Dependent Care Flexible Spending Account Program (the “Program”) is hereby established as a Benefit Program under the Plan effective as of June 30, 2004.

1.2 Program Purpose. The purpose of the Program is to enable Covered Participants to receive reimbursement of certain dependent care assistance expenses subject to the terms, conditions, and limitations set forth herein. It is intended that the Program qualify as a dependent care assistance program within the meaning of Code Section 129(d) and that the benefits payable under the Program be eligible for exclusion from gross income under Code Section 129(a).

1.3 Program Funding. The Program is unfunded and all contributions shall be considered a part of the general assets of the University and shall not be placed in trust. Nothing herein shall be construed to require the University to establish a trust or maintain any fund or segregate any amount for the benefit of Covered Participants unless otherwise required by law.

1.4 Program Document. This document evidences the provisions of the Program, including the requirements for enrollment, the types and amounts of benefits, and any other conditions or limitations regarding enrollment, coverage and benefits, pursuant to which reimbursement of certain dependent care assistance expenses are provided to Covered Participants. This document is intended to fully amend and restate the provisions of the prior program document and is hereby made a part of the Plan and its provisions are incorporated in the Plan.

ARTICLE II
DEFINITIONS

The Definitions set forth in the Plan shall have the same meaning for purposes of the Program except as provided in this Article II or elsewhere in the Program unless a different meaning is clearly required by the context. Additional terms shall have the meaning as provided in this Article II.

2.1. Coverage Level. “Coverage Level” shall mean the amount, not to exceed the Program Benefit Limitation, that a Covered Participant elects or is deemed to elect to have credited to his or her Dependent Care Flexible Spending Account for a Plan Year pursuant to Section 3.2.

2.2. Covered Participant. “Covered Participant” shall mean a Participant who enrolls or is deemed to enroll in the Program in accordance with Plan Section 5.2.

2.3. Dependent. “Dependent” shall mean any person who is (i) a dependent of a Covered Participant who is under the age of 13 and with respect to whom the Covered Participant is entitled to a deduction under Code Section 151(c) or (ii) a dependent or Spouse of the Covered Participant who is physically or mentally incapable of caring for himself or herself.

2.4. Dependent Care Flexible Spending Account. “Dependent Care Flexible Spending Account” shall mean the account described in Article IV.

2.5. Dependent Care Service Provider. “Dependent Care Service Provider” shall mean a person who provides care for a Dependent of a Covered Participant or for related household services, but shall not include (i) a related individual described in Code Section 129(c), or (ii) a dependent care center (as defined in Code Section 21(b)(2)(D)), unless the requirements of Code Section 21(b)(2)(C) are satisfied, provided, however, the limitations set forth in this clause (ii) shall not apply with respect to services provided inside the Covered Participant’s household.

2.6. Earned Income. “Earned Income” shall mean wages, salaries, tips and other employee compensation, plus net earnings from self-employment, computed without regard to any community property laws and excluding any amounts received as a pension or annuity, or paid or incurred by an employer for dependent care assistance including reimbursement of Qualifying Dependent Care Expenses. A Covered Participant’s Spouse who is either a full-time student at an educational institution or is physically or mentally incapable of caring for himself or herself shall be deemed, for each month during which such Spouse is either a full-time student at an educational institution or physically or mentally incapable of caring for himself or herself, to be gainfully employed and to have Earned Income of not less than:

(a) \$250 per month if the Covered Participant has only one (1) Dependent for the Plan Year; or

(b) \$500 per month if the Covered Participant has two (2) or more Dependents for the Coverage Period; or

(c) Such other dollar amounts as may be permitted under Code Section 21(d), which are hereby, incorporated in the Program by this reference.

Neither the University nor the Plan Administrator shall be responsible for determining the actual or deemed Earned Income of a Covered Participant's Spouse.

2.7. FSA Deposits. "FSA Deposits" shall mean the Participant Contributions that are made by a Covered Participant to pay for his or her enrollment in the Program. All Participant Contributions made by a Covered Participant under the Program are required to be made on a before-tax basis pursuant to a salary reduction agreement.

2.8. Program. "Program" shall mean the William Marsh Rice University Dependent Care Flexible Spending Account Program as set forth herein and as may be amended from time to time in accordance with Plan Section 8.1.

2.9. Program Benefit Limitation. "Program Benefit Limitation" shall mean the minimum and maximum Coverage Level a Covered Participant may elect to have credited to his or her Dependent Care Flexible Spending Account for the Plan Year. For each Plan Year, the Program Benefit Limitation as determined by the University, in its sole discretion, shall be set forth in such Plan Year's Benefits Booklet; provided, however, that the maximum Coverage Level shall not exceed the least of the following amounts:

- (a) \$5,000 for a Covered Participant who is single or who is married and files a joint federal income tax return, or \$2,500 for a Covered Participant who is married and files a separate return;
- (b) The Covered Participant's anticipated Earned Income for the Plan Year; or
- (c) If the Covered Participant is married on the last day of the Plan Year, the greater of (i) his or her Spouse's anticipated Earned Income for the Plan Year or (ii) the Spouse's deemed Earned Income for the Plan Year.

Notwithstanding the foregoing, the maximum Coverage Level for any Plan Year shall not exceed the exclusion limitations set forth in Code Sections 129(a)(2) and 129(b), and any changes to such exclusion limitations are hereby incorporated in the Program. For purposes of this Section, marital status shall be determined under Code Section 21(e).

2.10. Qualifying Dependent Care Expenses. "Qualifying Dependent Care Expenses" shall mean expenses incurred by a Covered Participant during a Plan Year which are: (i) incurred for the care of a Dependent of the Covered Participant or for related household services; (ii) paid or payable to a Dependent Care Service Provider; (iii) incurred to enable the Covered Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Covered Participant. "Qualifying Dependent Care Expenses" shall not include expenses for which: (i) reimbursement of the Qualifying Dependent Care Expenses is not applied for within the "run-out" period described in Section 6.2(a); (ii) a deduction or credit is claimed on the Covered Participant's income tax return; (iii) reimbursement or payment is received under another dependent care assistance program (other than under the Program); and (iv) are incurred for services outside the Covered Participant's household for the care of a Dependent unless the Dependent is a dependent who is

under the age of 13 and with respect to whom the Covered Participant is entitled to a deduction under Code Section 151(c) or regularly spends at least 8 hours each day in the Covered Participant's household; provided, however, such term shall not include any amount paid for services outside the Covered Participant's household at a camp where the Dependent stays overnight. Qualifying Dependent Care Expenses shall be deemed to be incurred at the time the services to which the expenses relate are rendered.

ARTICLE III
ENROLLMENT

3.1. Enrollment of Participants. A Participant may elect or waive enrollment in the Program during an Open Enrollment Period or may elect enrollment in the Program during a Special Enrollment Period. Upon enrollment, a Participant shall become a Covered Participant under the Program for the Plan Year. A Covered Participant may terminate an enrollment election during a Plan Year only if permitted under Plan Section 5.6.

3.2. Election of Coverage Level. A Covered Participant shall elect a Coverage Level for the Plan Year or the remainder of the Plan Year at the time of enrollment. A Covered Participant may revoke an existing enrollment election and change his or her Coverage Level during a Plan Year only if permitted under Plan Section 5.6.

3.3. Leaves of Absence. If a Covered Participant takes a paid or unpaid Leave of Absence his or her enrollment in the Program shall be suspended and shall terminate in accordance with Section 3.4 below. If a Covered Participant's enrollment in the Program is reinstated during the Plan Year in which the Leave of Absence begins pursuant to Plan Section 4.3(d), (i) his or her FSA Deposits shall resume at the rate in effect before his or her Leave of Absence began and (ii) his or her Coverage Level elected for the Plan Year shall be reduced to reflect FSA Deposits not made during the suspension period unless the Covered Participant elects to make up such missing FSA Deposits.

3.4. Suspension of Enrollment. If a Covered Participant's enrollment in the Program is suspended pursuant to Section 3.3 above or under Plan Section 4.4, his or her enrollment in the Program shall be suspended and shall terminate at the end of the Plan Year in which the suspension occurs unless active participation is reinstated earlier. If a Covered Participant's enrollment in the Program is reinstated during the Plan Year in which the suspension begins pursuant to Plan Section 4.4(c), (i) his or her FSA Deposits shall resume at the rate in effect before his or her suspension began and (ii) his or her Coverage Level elected for the Plan Year shall be reduced to reflect FSA Deposits not made during the suspension period unless the Covered Participant elects to make up such missing FSA Deposits.

3.5. Termination of Enrollment. A Covered Participant's enrollment in the Program shall terminate in accordance with Plan Section 4.6. If a Covered Participant's enrollment in the Program is reinstated during a Plan Year in which a Severance occurs pursuant to Plan Section 4.5(b), (i) his or her FSA Deposits shall resume at the rate in effect before his or her Severance and (ii) his or her Coverage Level elected for the Plan Year shall be reduced to reflect FSA Deposits not made during the severance period unless the Covered Participant elects to make up such missing FSA Deposits.

3.6. Extended Enrollment. Continuation Coverage is not available under the Program; provided, however, in the event a Covered Participant's enrollment is suspended or terminated during the Plan Year, Qualifying Dependent Care Expenses incurred during such Plan Year shall continue to be reimbursed until such time as the balance in his or her Dependent Care Flexible Spending Account is reduced to zero but no later than the end of the "run-out" period described in Section 6.2(a).

ARTICLE IV
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

4.1. Establishment of Accounts. The Plan Administrator shall establish and maintain on its books a Dependent Care Flexible Spending Account with respect to each Covered Participant for the Plan Year.

4.2. Crediting of Accounts. The Dependent Care Flexible Spending Account of each Covered Participant shall be credited on a pay period basis with an amount equal to his or her FSA Deposits made for such pay period. The amount credited to the Account shall only be used to reimburse for Qualifying Dependent Care Expenses incurred by the Covered Participant during such Plan Year and shall not be used to provide any other type of Benefit.

4.3. Debiting of Accounts. The Dependent Care Flexible Spending Account of each Covered Participant shall be debited from time to time by the amount of any reimbursement for Qualifying Dependent Care Expenses made to (or on behalf of) the Covered Participant during the Plan Year.

4.4. Forfeiture of Accounts. At the end of each Plan Year any unused balance in a Covered Participant's Dependent Care Flexible Spending Account shall be segregated from any credits to the Account for the following Plan Year and shall be held for the "run out" period described in Section 6.2(a). At the end of the run out period, any remaining amounts in a Covered Participant's Dependent Care Flexible Spending Account attributable to the prior Plan Year shall be forfeited.

ARTICLE V
PAYMENT OF BENEFITS

5.1. Reimbursement of Expenses. The Plan Administrator or if so designated by the Plan Administrator, the Claims Administrator shall reimburse a Covered Participant for Qualifying Dependent Care Expenses incurred during a Plan Year for which the Covered Participant submits a written claim and documentation in accordance with Section 6.2. Reimbursement of Qualifying Dependent Care Expenses may at the Plan Administrator's option, be paid directly to the provider of services. No reimbursement of Qualifying Dependent Care Expenses shall at any time exceed the balance then credited to a Covered Participant's Dependent Care Flexible Spending Account for the Plan Year at the time of the reimbursement. If Qualifying Dependent Care Expenses cannot be immediately reimbursed because the Covered Participant's Dependent Care Flexible Spending Account is insufficient, the unpaid portion of the claim shall be paid thereafter on such intervals as established by the Plan Administrator when and if the balance in the Account during the Plan Year in which the expense was incurred is sufficient to cover the reimbursement remaining due. Reimbursement shall be made only to the extent the Plan Administrator in good faith determines that a reimbursement can be provided on an income tax-free basis.

5.2. Maximum Reimbursement . Reimbursements under the Program for a Plan Year shall not exceed the Coverage Level elected by the Covered Participant for the Plan Year.

5.3. Discharge. Any reimbursement made under the Program shall fully discharge the obligations of the Program to the extent of such payment.

ARTICLE VI
CLAIMS FOR BENEFITS

6.1. Submission of Claims to Claims Administrator. If, at any time, the Program is administered by a Claims Administrator, the Plan Administrator may, in accordance with Plan Section 6.2(i), appoint and designate such Claims Administrator as the named fiduciary with respect to all or part of the claims and appeals procedures set forth in Sections 6.2 and 6.3 or may delegate to such Claims Administrator certain responsibilities with respect to all or part of the claims and appeals procedures set forth in Sections 6.2 and 6.3. In the event of such appointment and delegation, the term “Claims Administrator” shall be substituted for “Plan Administrator” in each place it appears in Sections 6.2 and 6.3 to the extent such appointment and delegation is applicable.

6.2. Claims Procedures. A Covered Participant shall follow the administrative procedures for filing a claim for benefits as set forth in this Section. Claims shall be reviewed in accordance with the procedures established by the Plan Administrator (or its delegate) subject to the following administrative procedures set forth in this Section.

(a) A Covered Participant must file a written claim for benefits with the Plan Administrator on or before October 31st following the close of each Plan Year (or such other date established by the University) in which the expense was incurred in the manner prescribed by the Plan Administrator. Failure to file a claim for benefits by October 31st following the close of each Plan Year shall invalidate in full any claim to such benefits except to the extent that the person applying for benefits under the Program can demonstrate to the Plan Administrator, (whose determination shall be final and conclusive) that it was not reasonably possible to file such claim and that such claim shall be filed as soon as reasonably possible. The Plan Administrator may, in its discretion, designate a Claims Administrator or claim official to process and review a claim for benefits.

(b) A written claim for benefits shall be filed in the manner prescribed by the Plan Administrator setting forth: (i) the amount, date and nature of the expense with respect to which a payment is requested; (ii) the name of the person, organization or entity to which the expense was or is to be paid; (iii) the taxpayer identification number of such person, organization or entity; provided, however, this clause (iii) shall not apply in the case of an organization described in Code Section 501(c)(3); (iv) the name of the person for whom the expense was incurred and the relationship of the person to the Covered Participant; and (v) the amount reimbursed or paid under any other arrangement or program, with respect to the expense. The claim shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amount of the expense, together with any additional information or documentation that the Plan Administrator may request.

(c) The Plan Administrator shall notify a Covered Participant of an adverse benefit determination by issuing a Notice of Denial, within a reasonable period of time but not later than 90 days after receipt of the claim by the Plan Administrator unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for processing the claim. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the

extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to the Covered Participant prior to the expiration of the initial 90-day period. In no event shall the extension exceed a period of 90 days from the end of the initial 90-day period.

(e) A Covered Participant who wishes to appeal a Notice of Denial shall follow the administrative procedures for filing an appeal as set forth in Section 6.3.

6.3. Appeals Procedures. A Covered Participant who wishes to appeal a Notice of Denial shall follow the administrative procedures for filing an appeal as set forth in this Section and shall exhaust such administrative procedures prior to seeking any other form of relief. Appeals shall be reviewed in accordance with the procedures established by the Plan Administrator (or its delegate) subject to the following administrative procedures set forth in this Section.

(a) A Covered Participant must file an appeal of a Notice of Denial with the Plan Administrator within 60 days after receipt of a Notice of Denial.

(b) The Covered Participant's appeal must be made in writing and may include written comments, documents, records, and other information relating to his or her claim. The Covered Participant may review all pertinent documents and, upon request, shall have reasonable access to or be provided free of charge, copies of all documents, records, and other information relevant to his or her claim.

(c) The Plan Administrator shall provide a full and fair review of the appeal as follows:

(i) The Plan Administrator shall take into account all claim related comments, documents, records, and other information submitted by the Covered Participant without regard to whether such information was submitted or considered under the initial determination or review of the initial determination.

(ii) The Plan Administrator shall provide a review that does not afford deference to the initial determination or review of the initial determination. The review shall be conducted by an individual (or committee of individuals) who is neither the individual (or individuals) who made the initial determination to issue the Notice of Denial nor a subordinate or subordinates of such individual or individuals.

(d) The Plan Administrator shall notify a Covered Participant of its determination (whether adverse or not) by issuing, as applicable, a Notice of Denial of Appeal or a notice of complete grant, within a reasonable period of time but not later than 60 days after receipt of the appeal by the Plan Administrator unless the Plan Administrator determines, in its discretion, that special circumstances require an extension of time for reviewing the appeal. If an extension of time is required, a written or electronic extension notice indicating the special circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision shall be furnished to the Covered Participant prior to the expiration of the initial

60-day period. In no event shall the extension exceed a period of 60 days from the end of the initial 60-day period.

6.4. Definitions. For purposes of this Article VI, the following definitions shall apply:

(a) “Notice of Denial” shall mean a written or electronic notice that is issued by the Plan Administrator to a Covered Participant following an adverse benefit determination which includes any denial, reduction, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, or failure to provide or make payment that is based on a determination of the Covered Participant’s eligibility to participate in the Plan or the Program. A Notice of Denial shall set forth, in a manner calculated to be understood by the Covered Participant, the following: (i) the specific reason or reasons for the adverse determination; (ii) the specific reference to pertinent provisions of the Plan or the Program upon which the benefit determination is based; (iii) a description of any missing or additional material or information necessary for the Covered Participant to perfect the claim and an explanation of why such material or information is necessary; and (iv) an explanation of the Program’s appeals procedures and the time limits applicable to such procedures.

(b) “Notice of Denial on Appeal” shall mean a written or electronic decision that is issued by the Plan Administrator following an adverse benefit determination (as defined in paragraph (a) above) upon appeal. A Notice of Denial on Appeal shall set forth, in a manner calculated to be understood by the Covered Participant, the following: (i) the specific reason or reasons for the adverse determination on appeal; (ii) the specific reference to pertinent provisions of the Plan or the Program upon which the benefit determination is based; and (iii) a statement that the Covered 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 Covered Participant’s claim for benefits.

6.5. Review Procedures for Eligibility Determination. If an Employee has not filed a claim for benefits and has not been issued a Notice of Denial under Section 6.2 but believes that he or she is being denied enrollment under the Program, such Employee shall follow the administrative procedures for review as set forth in Plan Section 7.3.

ARTICLE VII
MISCELLANEOUS

7.1. Amendment or Termination of Program. The University reserves the right to amend the provisions of the Program or terminate or eliminate the Program at any time or times and for any or no reason as set forth in Plan Articles III and VIII. Upon termination or discontinuance of the Program, all enrollment shall end but reimbursements for previously incurred expenses shall be made in accordance with Article V.

7.2. Reimbursement by Covered Participants. If any Covered Participant receives reimbursements under Article V that are not for Qualifying Dependent Care Expenses, the Covered Participant shall reimburse the amount to the University and shall hold the University and Plan Administrator harmless from any liability each may incur for failure to withhold federal or state income taxes, payroll or employment taxes from the reimbursement.

7.3. Statement of Expenses. The University shall furnish to each Covered Participant, on or before January 31, a written statement showing the amount of Qualifying Dependent Care Expenses reimbursed or paid under the Program to such Covered Participant during the previous calendar year as required by Code Section 129(d)(7).

7.4. Nondiscrimination Requirements. For each Plan Year, the Benefits provided under the Program shall satisfy the nondiscrimination requirements imposed by the Code Section 129(d)(8).

7.5. Interpretation. Article and Section headings are for convenient reference only and shall not be deemed to be part of the substance of this document or in any way to enlarge or limit the contents of any Article or Section. The provisions of the Program shall in all cases be interpreted in a manner that is consistent with (i) the Program qualifying as a dependent care assistance program within the meaning of Code Section 129(d) and (ii) the exclusion from gross income of payments or reimbursements made hereunder in accordance with Code Section 129(a).