

**WILLIAM MARSH RICE UNIVERSITY
MEDICAL
FLEXIBLE SPENDING ACCOUNT PROGRAM**

Effective June 30, 2004

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TABLE OF CONTENTS

	<u>PAGE</u>
ARTICLE I	
INTRODUCTION	1
1.1 Amendment and Restatement of Program	1
1.2 Program Purpose	1
1.3 Program Funding	1
1.4 Program Document	1
ARTICLE II	
DEFINITIONS	2
2.1 Coverage Level	2
2.2 Covered Participant	2
2.3 Dependent	2
2.4 FSA Deposits	2
2.5 Medical Flexible Spending Account	2
2.6 Program	2
2.7 Program Benefit Limitation	2
2.8 Qualifying Health Care Expenses	2
ARTICLE III	
ENROLLMENT	3
3.1 Enrollment of Participants	3
3.2 Election of Coverage Level	3
3.3 Leaves of Absence	3
3.4 Suspension of Enrollment	3
3.5 Termination of Enrollment	3
3.6 Extended Enrollment	3
ARTICLE IV	
MEDICAL FLEXIBLE SPENDING ACCOUNT	5
4.1 Establishment of Accounts	5
4.2 Crediting of Accounts	5
4.3 Debiting of Accounts	5
4.4 Forfeiture of Accounts	5

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TABLE OF CONTENTS

	<u>PAGE</u>
ARTICLE V	
PAYMENT OF BENEFITS	6
5.1 Reimbursement of Expenses.....	6
5.2 Maximum Reimbursement.....	6
5.3 Discharge	6
ARTICLE VI	
CLAIMS FOR BENEFITS	7
6.1 Submission of Claims to Claims Administrator	7
6.2 Claims Procedures	7
6.3 Appeals Procedures.....	8
6.4 Definitions	9
6.5 Review Procedures for Eligibility Determination	10
ARTICLE VII	
MISCELLANEOUS	11
7.1 Amendment or Termination of Program.....	11
7.2 Reimbursement by Covered Participants.....	11
7.3 Interpretation.....	11

ARTICLE I
INTRODUCTION

1.1 Amendment and Restatement of Program. The William Marsh Rice University Medical Spending Account 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 health expenses subject to the terms, conditions, and limitations set forth herein. It is intended that the Program qualify as an accident and health plan within the meaning of Code Section 105(e) and that the benefits payable under the Program be eligible for exclusion from gross income under Code Section 105(b).

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 health 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 Medical 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 (i) a Spouse of the Covered Participant or (ii) a dependent of the Covered Participant as defined in Code Section 152.

2.4. 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.

2.5. Medical Flexible Spending Account. “Medical Flexible Spending Account” shall mean the account described in Article IV.

2.6. Program. “Program” shall mean the William Marsh Rice University Medical Flexible Spending Account Program as set forth herein and as may be amended from time to time in accordance with Plan Section 8.1.

2.7. 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 Medical 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.

2.8. Qualifying Health Care Expenses. “Qualifying Health Care Expenses” shall mean expenses incurred by a Covered Participant or his or her Dependent during a Plan Year for “medical care” as defined in Code Section 213(d) which are not otherwise reimbursed or paid through insurance (other than under the Program) but excluding expenses: (i) for which a reimbursement claim is filed for within the “run-out” period described in Section 6.2(a); (ii) for the payment of premiums under a health insurance plan, (iii) for the payment of qualified long term care services (as defined in Code Section 7702B), and (iv) for non-prescription drugs incurred prior to July 1, 2003. Notwithstanding the foregoing, Qualifying Health Care Expenses for a Plan Year shall not include expenses that are incurred during period(s) when enrollment in the Program is either suspended or terminated.

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. A Covered Participant who takes a paid Leave of Absence shall be treated in the same manner as if he or she was actively employed by the University for purposes of the Program. A Covered Participant who takes an unpaid Leave of Absence may continue enrollment in the Program during such Leave of Absence or may change or terminate enrollment as provided under Plan Section 4.3(b). 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. A Covered Participant may extend his or her enrollment in the Program under election procedures established by the University as follows:

(a) Continuation Coverage. A Covered Participant who is Qualified Beneficiary (as defined in Section 5.2(d) of the William Marsh Rice University Medical

Program) whose enrollment would otherwise terminate under the Program may elect Continuation Coverage upon the occurrence of a Qualifying Event (as defined in Section 5.2(e) of the William Marsh Rice University Medical Program) for the remainder of the Plan Year in which the Qualifying Event occurred. Participant Contributions for Continuation Coverage under the Program shall be remitted by the Covered Participant to the University, the amount of which shall be computed by the University in accordance with the applicable Continuation Coverage provisions of the William Marsh Rice University Medical Program. A Covered Participant's enrollment under this paragraph shall cease as set forth above unless ceased earlier under Plan Section 4.6.

(b) In the event a Covered Participant's enrollment is suspended or terminated during the Plan Year, Qualifying Health Care Expenses incurred during such Plan Year but prior to such suspension or termination shall continue to be reimbursed until such time as the balance in his or her Medical 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
MEDICAL FLEXIBLE SPENDING ACCOUNT

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

4.2. Crediting of Accounts. The Medical Flexible Spending Account of each Covered Participant shall be credited with an amount equal to the Coverage Level elected by the Covered Participant for the Plan Year subject to the reduction for suspended or terminated enrollment during the Plan Year. The amount credited to such Account shall only be used to reimburse for Qualifying Health Care Expenses incurred by the Covered Participant or his or her Dependents during such Plan Year and shall not be used to provide any other type of Benefit.

4.3. Debiting of Accounts. The Medical Flexible Spending Account of each Covered Participant shall be debited from time to time by the amount of any reimbursement for Qualifying Health Care Expenses made to a 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 Medical 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 the Covered Participant's Medical 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 Health 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 Health Care Expenses may at the Plan Administrator's option, be paid directly to the provider of services. For the purpose of reimbursements under the Program, a Covered Participant's Medical Flexible Spending Account as reduced for prior reimbursements during the Plan Year shall be available to the Covered Participant at all times during the Plan Year and shall be made only to the extent the Plan Administrator in good faith determines that 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 Claimant 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 Claimant 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 name of the person for whom the expense was incurred and, if such person is not the Covered Participant requesting the benefit, the relationship of the person to the Covered Participant; and (iv) the amount recovered under any insurance arrangement or other plan, 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 Claimant of an adverse benefit determination by issuing a Notice of Denial, within a reasonable period of time, but not later than 30 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 Claimant prior to the expiration of the initial 30-day period. If the extension is necessary for reasons beyond the Plan Administrator's control, the extension shall not exceed a period of 15 days from the end of the initial 30-day period. If the extension is necessary because of the failure of a Claimant to provide missing information and the Claimant is so notified of such fact, the extension shall not exceed a period of 15 days beginning as of the earlier of (i) the date the Claimant response is received by the Plan Administrator (without regard to whether all the missing information is provided) or (ii) the end of the period afforded to the Claimant to provide the missing information. The Claimant shall be afforded at least 45 days from the receipt of the notice within which to provide the missing information.

(d) Upon a determination by the Plan Administrator (excluding a determination made as a result of an amendment to or the termination of the Plan or the Program) to reduce or terminate benefits approved under a previously filed claim for benefits, the Plan Administrator shall provide the Claimant with a written or electronic Notice of Denial sufficiently in advance to appeal the determination before the reduction or termination of benefits occur.

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

6.3. Appeals Procedures. A Claimant who wishes to appeal a Notice of Denial shall follow the administrative procedures for 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 Claimant must file an appeal of a Notice of Denial with the Plan Administrator within the following time periods:

(i) 60 days after receipt of a Notice of Denial with respect to a claim for benefits resulting from a determination by the Plan Administrator to reduce or terminate benefits approved under a previously filed claim for benefits; or

(ii) 180 days after receipt of any other Notice of Denial.

(b) The Claimant's appeal must be made in writing and may include written comments, documents, records, and other information relating to his or her claim. The Claimant 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 Claimant

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 Claimant of its decision upon review of an appeal (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 appropriate to the medical circumstances, but not later than 60 days after receipt of the appeal by the Plan Administrator.

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

(a) “Authorized Representative” shall mean any person or entity designated as such by a Claimant in accordance with reasonable procedures established by the Plan Administrator.

(b) “Claimant” shall mean any Participant or any Covered Participant under the Program (or his or her Authorized Representative) who files a claim for benefits. The term “Claimant” shall also include any individual who after initiating and filing a claim for benefits is denied benefits because the individual is determined not to be eligible for coverage under the Plan or the Program.

(c) “Notice of Denial” shall mean a written or electronic notice that is issued by the Plan Administrator to a Claimant following an adverse benefit determination, which includes any 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 the Claimant’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 Claimant, 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 Claimant 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, including a statement of the Claimant’s right to bring a civil action under Section 502(a) of ERISA following a Notice of Denial on Appeal. The Notice of Denial shall also to the extent applicable set forth the internal rule, guideline, protocol or other similar criterion upon which the Notice of Denial was based or indicate that such was relied upon and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request.

(d) “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 (c) above) upon appeal. A Notice of Denial on Appeal shall set forth, in a manner calculated to be understood by the Claimant, 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; (iii) a statement that the Claimant 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 Claimant’s claim for benefits; and (iv) a statement of the Claimant’s right to bring a civil action under Section 502(a) of ERISA. The Notice of Denial on Appeal shall also to the extent applicable set forth the internal rule, guideline, protocol or other similar criterion upon which the Notice of Denial on Appeal was based or indicate that such was relied upon and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge upon request.

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 Health 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. 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 an accident and health plan within the meaning of Code Section 105(e) and (ii) the exclusion from gross income of reimbursements made hereunder in accordance with Code Section 105(b).