MEDICAL REIMBURSEMENT PLAN
West Virginia Annual Conference
The United Methodist Church

Effective Date: January 1, 2004

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PURPOSE

The Medical Reimbursement Plan (the “Plan”) has been adopted by the West Virginia Annual Conference (Empyer) effective January 1, 2004. The purpose of the Plan is to help provide full and complete medical care for Participants and their Dependents, as defined herein. The Plan is intended to provide reimbursement of medical and hospitalization expenses that exceed the deductible or co-payment limits of any insurance policies covering such costs or which are otherwise not covered by insurance or provided by the Employer. The Employer intends that the Plan qualify as an accident and health plan within the meaning of Section 105(e) of the Internal Revenue Code (the “Code”) and that the benefits provided under the Plan be eligible for exclusion from the Participant’s income for Federal Income Tax purposes under Section 105(b) of Code.

Section 1

DEFINITIONS

The following words and phrases as used herein shall have the following meanings, unless a different meaning is plainly required by the context. Pronouns shall be interpreted so that the masculine pronoun shall include the feminine and the singular shall include the plural, and the following rules of interpretation shall apply in reading this instrument:

1.1 “Benefit Credits” means that amount allocated to the provision of Eligible Medical or Dental Expense reimbursement under this Plan pursuant to Section 2.5 herein.

1.2 “Benefits or Reimbursable Expense” means any amounts paid to a Participant in the Plan as reimbursement for Eligible Medical or Dental Expenses incurred during a Plan Year by the Participant, his Spouse or his Dependents.
1.3 "Board" means the Board of Directors of XYZ, Inc.

1.4 "Cafeteria Plan" means XYZ, Inc. Flexible Benefits Plan.

1.5 "Code" means the Internal Revenue Code of 1986, and the same as may be amended from time to time.

1.6 "Committee" means the individuals who may be appointed by the Board to administer the process of claims review for the Plan in accordance with Section 4.

1.7 "Compensation" means earned income, salaries, wages, fees, commissions, overtime, bonuses, tips and all other earnings of a Participant reportable on Form W-2 for the Plan Year, including amounts contributed by an Employee to the Plan, but excluding all other contributions to any other Plan sponsored by the Employer; and all other forms of Compensation.

1.8 "Dependent" means:

A. The person, persons, or trust designated by a written revocable designation filed with the Plan Administrator by the Participant to receive payments under the Plan, including the Participant and any dependents of the Participant.

B. Effective August 10, 1993, or the effective date of the Plan, if later, the Participant's dependents shall include dependent children placed with the Participant or a beneficiary for adoption, irrespective of whether the adoption has become final (provided the child has not attained age 18 as of the date of adoption or placement), and such children shall benefit under the Plan under the same terms and conditions as apply to dependent children who are natural children of the Participant or beneficiary. For purposes of the preceding sentence, "placed" or "placement" means the assumption and retention of a legal obligation for total or partial support of such child in anticipation of adoption of such child. Such placement shall end with the termination of such legal obligation. Coverage of a child adopted by or placed with a Participant or a beneficiary shall not be restricted solely on the basis of a pre-existing condition of such child at the time that such child would otherwise become eligible under the Plan, if the adoption or placement occurs while the Participant or beneficiary is eligible for coverage under the Plan.

1.9 "Compensation Reduction Agreement" means the voluntary agreement by an Employee to reduce his Compensation for the forthcoming Plan Year (or, if the agreement becomes effective after the beginning of the Plan Year, for the balance of the Plan Year), for purposes of obtaining the Qualified Benefits offered by the Plan.

1.10 "Effective Date" means January 1, 1994.

1.11 "Eligible Employee" means any Employee who is defined as such in the Cafeteria Plan.

1.12 "Eligible Medical or Dental Expenses" means those expenses incurred by the Participant, or the Participant's Spouse or Dependents, after the effective date of the Participant's participation herein and during the Plan Year otherwise allowable as deductions under Code section 213 (without regard to the limitations contained in section 213(a)), but shall not include an expense incurred (A) for the payment of premiums under a health insurance plan not sponsored
by the Company, or (B) for the purpose of cosmetic surgery as defined by Code section 213(d)(9). For purposes of this Plan, an expense is incurred" when the Participant or beneficiary is furnished the medical care or services giving rise to the claimed expense.

1.13 "Employee" means any individual who is defined as such in the Cafeteria Plan.

1.14 "Employer" means XYZ, Inc., any other business organization which succeeds to its business and elects to continue this Plan.

1.15 "Enrollment Period" means the period of time defined as such in the Cafeteria Plan.

1.16 "Entry Date" means the first day of employment as an Eligible Employee.

1.17 "Highly Compensated Individual" means any Employee defined as such in section 105(h) of the Code.

1.18 "Key Employee" means any Employee defined as such in section 416(i)(1) of the Code.

1.19 "Participant" means any Eligible Employee who has met the conditions for participation set forth in Section 2.1, and who has allocated a portion of his Benefit Credits to the provision of Eligible Medical or Dental Expense reimbursement. An alternate recipient described in Section 7.4 shall also be treated as a Participant for purposes of the reporting and disclosure requirements under the Plan and ERISA.

1.20 "Participating Employer" means the Employer and any affiliated company which adopts the Plan with the consent of the Board. As of the Effective Date the Employer was the only Participating Employer in the Plan.

1.21 "Plan" means XYZ, Inc. Medical Reimbursement Plan, described herein.

1.22 "Plan Administrator" means the Employer.

1.23 "Plan Year" means each twelve-month period commencing each January 1 and ending on December 31.

1.24 "Spouse" means an individual who is legally married to a Participant but shall not include an individual legally separated from a Participant under a decree of legal separation.

Section 2

PARTICIPATION IN THE PLAN

2.1 Commencement of Participation. Each Eligible Employee shall be eligible to become a Participant in the Plan as of his Entry Date.

2.2 Procedure for and Effect of Participation. An Eligible Employee may become a Participant in the Plan by executing a Compensation Reduction Agreement and providing such data as are reasonably required by the Employer as a condition of such participation. By becoming a Participant, each individual shall for all purposes be deemed conclusively to have consented to the provisions of this Plan and to those of the Cafeteria Plan, and to all amendments thereto.

2.3 Cessation of Participation. A Participant will cease to be a Participant as of the earliest of:
A. the date on which the Plan terminates;
B. the date on which he ceases to be an Eligible Employee; or
C. the date on which he voluntarily ceases to be a Participant pursuant to the terms of the Cafeteria Plan.

Nothing in this Section 2.3 shall prohibit the payment of Benefits with respect to claims arising prior to the Participant's termination of participation.

Notwithstanding the foregoing, a former Participant who continues to receive Compensation from the Employer shall remain a Participant for all purposes until the date such Compensation ceases.

2.4 Recomencement of Participation. A former active Participant will recommence participation as of his date of reemployment. A reemployed former active Participant may not make a new election which is effective during the Plan Year in which he separated from service with the Employer.

2.5 Annual Elections. For any Plan Year, a Participant may affirmatively elect to receive Benefit Credits to be applied to the Benefits provided by this Plan by filing a Compensation Reduction Agreement form, which may be obtained from the Employer, and which shall specify the exact amount of the Participant's Compensation which the Participant wishes to receive as Benefit Credits instead of in cash Compensation during the period covered by the Compensation Reduction Agreement. The initial Compensation Reduction Agreement filed by any Participant who is an Eligible Employee shall become effective on the first day of the first pay period, as applicable to the Participant, which commences after such election form is submitted, properly signed and dated, by the Participant to the Employer and accepted on behalf of the Employer. Any subsequent Compensation Reduction Agreement filed by such a Participant shall become effective on the first day of the subsequent Plan Year for which such election is made. If any Participant fails to file a Compensation Reduction Agreement during the Enrollment Period he shall be deemed to have elected to receive cash Compensation under this Plan in accordance with Section 3.6.

2.6 Duration of Elections. Once effective, any such affirmative or deemed Compensation Reduction Agreement shall remain in effect until the end of the Plan Year for which it was made, unless a change is made pursuant to the terms of the Cafeteria Plan. No change or revocation of a Compensation Reduction Agreement under this Plan shall be permitted, except any change or revocation made in accordance with the terms of the Cafeteria Plan.

Section 3

BENEFITS

3.1 Provision of Benefits. Benefits under this Plan shall take the form of reimbursement by the Employer for Eligible Medical or Dental Expenses incurred by a Participant during the Plan Year. A Participant shall be entitled to benefits under this Plan only for Eligible Medical or Dental Expenses incurred after becoming a Participant.

3.2 Amount of Reimbursement. A Participant shall be entitled to benefits under this Plan in an amount that does not exceed his Benefit Credits. Eligible Medical or Dental Expenses shall be reimbursed up to the amount of a Participant's Benefit Credits for a Plan Year. Each payment hereunder shall be a charge to the Participant's Benefit Credits. A Participant's Benefit Credits
under this Plan shall be uniformly available throughout the Plan Year.

3.3 Limitations on Reimbursement. The Employer's payment of benefits under this Plan for any Plan Year will be limited to the lesser of (i) the Participant's Eligible Medical or Dental Expenses for the year, or (ii) the Participant's Benefit Credits.

3.4 Covered Expenses. Reimbursement shall be provided to any individual only for Eligible Medical or Dental Expenses incurred while that individual is a Participant. Reimbursement for Eligible Medical or Dental Expenses incurred during a period of participation may be made after such participation ceases. An Eligible Medical or Dental Expense shall be considered incurred when the goods or services giving rise to such Eligible Medical or Dental Expense are provided, irrespective of when such Eligible Medical or Dental Expenses are billed to the Participant. Reimbursement shall not be made for any amount that does not qualify as an Eligible Medical or Dental Expense, and no Participant or former Participant shall receive any amount by which his Benefit Credits allocated under the Cafeteria Plan for Eligible Medical or Dental Expense reimbursement exceed the amount actually paid as reimbursement for Eligible Medical or Dental Expenses.

3.5 Maximum Annual Benefits. A Participant may not receive reimbursement for Eligible Medical or Dental Expenses incurred by him for the Plan Year in excess of the amount set forth in Schedule A attached hereto to effectuate the Plan, and such action shall be conclusive. Records of administration of the Plan shall be kept, and Participants and their beneficiaries may examine records pertaining directly to the individual.

3.6 Cash Alternative. Any Participant who has not elected under the procedures described in Section 2 to receive Benefit Credits will be assumed to have elected cash Compensation, and his Compensation will not be reduced to cover the payment of non-cash Benefit Credits under this Plan.

3.7 Nondiscriminatory Benefits. The Plan is intended not to discriminate in favor of Highly Compensated Individuals as to eligibility to participate, contributions and Benefits, and to comply in this respect with the requirements of the Code. If, in the judgment of the Plan Administrator, the operation of the Plan in any Plan Year would result in such discrimination, then the Plan Administrator shall select and exclude from coverage under the Plan such Highly Compensated Individuals who are Plan Participants, and/or reduce contributions and/or Benefit Credits under the Plan by Highly Compensated Individuals who are Plan Participants, to the extent necessary to assure that, in the judgment of the Plan Administrator, the Plan does not discriminate.

3.8 Maximum Overall Contributions. No Participant shall be entitled to reduce Compensation by more than the aggregate maximum amount of Benefit Credits specified in the Cafeteria Plan.

3.9 Forfeiture of Unused Benefits. A Participant shall receive no reimbursement for Benefit Credits which are elected but unused during a Plan Year or not submitted for reimbursement by the end of three months following the end of the Plan Year or participation in the Plan, for any reason.

Section 4

ADMINISTRATION
4.1 Administrator. The Employer shall be the Plan Administrator of the Plan for purposes of ERISA.

4.2 Named Fiduciary. The Employer shall be the named fiduciary responsible for administration of the Plan. The Employer may, however, delegate any of its powers or duties under the Plan in writing to any person or entity. The delegate shall become the fiduciary for only that part of the administration which has been delegated by the Employer and any references to the Employer shall instead apply to the delegate.

However, if the Employer assigns any of the Employer's responsibility to an Employee, it will not be considered a delegation of Employer responsibility but rather how the Employer internally is assigning responsibility.

4.3 Rules of Administration. The Employer shall adopt such rules for administration of the Plan as it considers desirable, provided they do not conflict with the Plan; and may construe the Plan, correct defects, supply omissions and reconcile inconsistencies to the extent necessary to

4.4 Services to the Plan. The Employer may contract for legal, actuarial, investment advisory, medical accounting, clerical, claims administration and other services to carry out the Plan. The costs of such services and other administrative expenses shall be paid by the Employer.

4.5 Funding Policy. The Employer may periodically at its discretion review and determine the funding policy of the Plan, with the advice of such experts as the Employer deems appropriate.

4.6 Claims Procedure.

A. To receive benefits under the Plan, a Participant must submit a written claim for benefits to the Plan Administrator. For purposes of the claims procedure, the Employer has assigned the Human Resources Department to be the Plan Administrator.

The Plan Administrator will review the claim and will advise the Participant of any Benefit to which he is entitled. If a Participant believes he has not been reimbursed in accordance with the Plan or has not been advised of his Benefits, he may submit a written request to the Plan Administrator to provide either an explanation of how Benefits are reimbursed or further information of his Benefits. The Plan Administrator must respond to such a request within a reasonable time.

Additionally, the Plan Administrator will provide to every claimant, who is denied a claim for Benefits, a written notice stating in a format determined to be understood by the claimant:

(i) the specific reason or reasons for the denial;

(ii) specific reference to pertinent plan provisions on which the denial is based;

(iii) a description of any additional material or information necessary for the claimant to perfect the claim; and

(iv) an explanation of the claim review procedure set forth in Paragraph B., below.

B. Within 60 days of receipt by a claimant of a notice denying a claim under Paragraph A., the claimant or his duly authorized representative may request in writing a full and fair review of the claim by
the Plan Administrator or by the Committee which may be appointed by the Employer for that purpose. The Plan Administrator may extend the 60-day period where the nature of the benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, the claimant or his duly authorized representative may review pertinent documents and may submit issues and comments in writing. The Plan Administrator or committee shall make a decision promptly, and not later than 60 days after the Plan Administrator’s receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the committee deems one necessary) require an extension of time for processing, in which case a decision shall be rendered as soon as possible, but not later than 120 days after receipt of a request for review. The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based. If the decision on review is not made within such period, the claim will be considered denied.

4.7 Nondiscriminatory Operation. All rules, decisions and designations by the Employer and each administrative committee under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike.

4.8 Liability of Administrative Personnel. Neither the Employer, nor any of its Employees, nor any provider of services under Section 4.4 herein, shall be liable for any loss due to an error or omission in administration of the Plan unless the loss is due to the gross negligence or willful misconduct of the party to be charged or is due to the failure of the party to be charged to exercise a fiduciary responsibility, if one is owed, with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

Section 5

CONTRIBUTIONS AND PAYMENT OF BENEFITS

5.1 Funding. The Eligible Medical or Dental Expense reimbursement provided in the Plan shall be paid by the Employer; provided, however, that the Employer’s payments under the Plan to or on behalf of a Participant shall be limited to such amounts of Compensation as the Participant elects to forego pursuant to a Compensation Reduction Agreement and allocated to the provision of Eligible Medical or Dental Expense reimbursement.

5.2 Claims for Benefits. No benefit shall be paid under the Plan unless a Participant has first submitted a written claim for Benefits to the Plan Administrator on a form specified by the Plan Administrator, and pursuant to the procedures set out in the Employer’s Cafeteria Plan and Section 5.3.

5.3 Reimbursement of Eligible Medical or Dental Expenses. Each Participant who desires to receive reimbursement under the Plan for Eligible Medical or Dental Expenses incurred for Qualifying Services shall submit to the Plan Administrator, at the times indicated in Section 5.5, a form provided by the Employer, or responses to other supplementary factual requests, containing the following information:

A. the name of the person or persons on whose behalf Eligible Medical or Dental Expenses have been incurred;

B. the nature of the expenses so incurred;
C. the date the expenses so incurred;
D. the amount of the requested reimbursement; and
E. that such expenses have not otherwise been paid through insurance or reimbursed from any other source.

As soon as is administratively feasible following the end of each week, the Plan Administrator or his designated claims administration representative shall review all the forms submitted by Participants during that week in accordance with the foregoing procedures and shall pay each Participant the Benefit Credits which each Participant is entitled to receive under the Plan, in accordance with the Plan.

5.4 Cash Benefits. Each Participant electing to receive cash Compensation shall receive his Compensation without any reduction.

5.5 Time Limit. No Benefit Credits shall be paid or expense reimbursed under Section 3 for any Plan Year unless the Participant applies for such Benefit or reimbursement within the earlier of three months after the end of such Plan Year or three months following a Participant’s date of termination.

5.6 Source of Benefit Payments. The sole source for payment of Benefit Credits under this Plan shall be the unfunded accounts established for each Participant pursuant to his election under Section 2.5 to receive such Benefit Credits. The Plan Administrator shall pay to each Participant the Benefit Credits which he is entitled to receive under this Plan, and his reimbursement account under the Plan shall be debited accordingly. The aggregate reimbursements made as of any time during the Plan Year shall not exceed the Participant’s total Plan contributions for Benefit Credits previously made during the Plan Year.

5.7 Forfeitability of Unpaid Benefits. Any balance remaining in the Participant’s reimbursement account after the last Eligible Medical or Dental Expenses have been paid for a given Plan Year shall be forfeited by the Participant, and the account balance reduced to zero.

5.8 No Reversion to Employer. At no time shall any part of Plan assets be used for, or diverted to, purposes other than for the exclusive benefit of Plan Participants or their beneficiaries, or for defraying reasonable expenses of administering the Plan.

Section 6
CONTINUATION OF COVERAGE

6.1 In General. The following provisions shall apply to Benefits provided to Eligible Employees and their dependents under the Plan, but only to the extent that the Benefits selected pertain to health care and medical coverage. This coverage shall be continued pursuant to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) Title X (COBRA).

6.2 Continuation of Coverage. To the extent required by Section 6.1 above, a qualified beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

Except as otherwise specified in an election, any election by a qualified beneficiary who is a
covered Employee or Spouse of the covered Employee will be deemed to include an election for continuation coverage under this provision on behalf of any other qualified beneficiary who would lose coverage by reason of a qualifying event.

If this Plan provides a choice among the types of coverage under this Plan, each qualified beneficiary is entitled to make a separate selection among such types of coverage (i.e. single, family, etc.).

6.3 Type of Coverage. Continuation coverage under this provision is coverage which is identical to the coverage provided under this Plan to similarly situated beneficiaries under this Plan with respect to whom a qualifying event has not occurred as of the time coverage is being provided. If coverage under this Plan is modified for any group of similarly situated beneficiaries, the coverage shall also be modified in the same manner for all qualified beneficiaries under this Plan in connection with such group.

6.4 Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a qualifying event and ending not earlier than the earliest of the following:

A. in the case of a terminated Employee (except for gross misconduct) or a covered Employee whose hours have been reduced, except as provided in B. and C. below, and his covered dependents, the date which is 18 months after the qualifying event;

B. in the case of a qualified beneficiary disabled at the time of the covered Employee’s termination (except for gross misconduct) the date which is 29 months after the qualifying event, provided the qualified beneficiary provides the Plan Administrator with notice of Social Security disability determination within 60 days of the disability determination and within 18 months of the qualifying event;

C. in the case of a qualifying event which occurs during the 18 months after the date that a covered Employee is terminated (except for gross misconduct) or the date that a covered Employee’s hours are reduced, for the covered dependents, the date which is 36 months after the date that a covered Employee is terminated (except for gross misconduct), or the date that a covered Employee’s hours are reduced;

D. in the case of a termination (except for gross misconduct) or reduction in hours of a covered Employee and that Employee’s subsequent entitlement to Medicare while continuation coverage is in force, for the covered qualified beneficiaries, the date which is 36 months from date of entitlement to Medicare;

E. in the case of any qualifying event except as described in A., B., C. and D. above, the date which is 36 months after the date of the qualifying event;

F. the date on which the Participating Employer ceases to provide any group health plan to any Employee;

G. the date on which the qualified beneficiary fails to make timely payment of the required contribution pursuant to this provision;

H. the date on which the qualified beneficiary first becomes, after the date of the election, covered under any other group health plan as an employee or dependent, or
otherwise becomes entitled to benefits under Title XVIII of the Social Security Act (Medicare). However, if the other group health plan has a preexisting condition limitation, coverage under the Plan will not cease while such preexisting condition limitation under the other group plan remains in effect, subject to the maximum period of coverage limitations set forth in this Section 6.4.

6.5 Contribution.

A. A qualified beneficiary shall only be entitled to continuation coverage provided such qualified beneficiary pays the applicable premium required by the Employer in full and in advance, except as provided in B. below. Such premium shall not exceed the requirements of applicable federal law. A qualified beneficiary may elect to pay such premium in monthly installments.

B. Except as provided in C. below, the payment of any premium shall be considered to be timely if made within 30 days after the date due, or within such longer period of time as applies to or under this Plan.

C. Notwithstanding A. and B. above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required premium for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

6.6 Notification by Qualified Beneficiary. Each covered Employee or qualified beneficiary must notify the Employer of the occurrence of a divorce or legal separation of the covered Employee from such covered Employee's Spouse, and/or the covered Employee's dependent child ceasing to be a dependent child under the terms of this Plan within 60 days after the date of such occurrence. This 60-day time limit shall only apply to those occurrences as described in this paragraph which occur after the date of the enactment of the Tax Reform Act of 1986.

6.7 Notification to Qualified Beneficiary.

A. The Employer shall provide written notice to each covered Employee and Spouse of such covered Employee of his/her right to continuation coverage under this provision as required by federal law.

B. The Employer shall notify any qualified beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the covered Employee from the covered Employee's Spouse or a dependent child ceasing to be a dependent child under the terms of this Plan, the Employer shall only be required to notify a qualified beneficiary of his/her right to elect continuation coverage if the covered Employee or the qualified beneficiary notifies the Employer of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within 60 days after the date of such qualifying event.

C. Notification of the requirements of this provision to the Spouse of a covered Employee shall be treated as notification to all other qualified beneficiaries residing with such Spouse at the time notification is made.

6.8 Definitions. The italicized terms used in the text of this Section 6 are defined as follows:

A. "Dependents" means an individual who meets the definition of dependent under the Par-
icipating Employer’s health plan covering the Eligible Employee or who is a dependent within the meaning of section 152(a) of the Code.

No person shall be considered a dependent of more than one Employee.

If both an Employee and an Employee’s Spouse are employed by XYZ, Inc., dependent children may be covered by either Spouse, but not by both.

B. “Election Period” means the 60-day period during which a qualified beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than 60 days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

C. “Full-Time Student” means a dependent child who is enrolled in, regularly attends and is recognized by the Registrar of an accredited secondary school, college or university, institution for the training of registered nurses (R.N.), or any other accredited or licensed school for the minimum number of credit hours required by that institution in order to maintain Full-Time Student status.

D. “Medicare” means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

E. “Qualified Beneficiary” means an individual who, on the day before the qualifying event for a covered Employee, is a beneficiary under this Plan as the spouse or dependent child of the covered Employee. In the case of the termination of a covered Employee (except by reason of such covered Employee’s gross misconduct) or the reduction in hours of the covered Employee’s employment, the term qualified beneficiary includes the covered Employee.

Exception — the term qualified beneficiary does not include an individual whose status as a covered Employee is attributable to a period in which such individual is a nonresident alien who received no earned income from the employer which constituted income from sources within the United States (within the meaning of Code section 91 l(d)(2) and section 86l(a)(3)). If an individual is not a qualified beneficiary pursuant to this paragraph, a spouse or dependent child of such individual shall not be considered a qualified beneficiary by virtue of the relationship to such individual.

F. “Qualifying Event” means with respect to a covered Employee, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a qualified beneficiary:

(i) the death of the covered Employee;

(ii) the termination (except by reason of such covered Employee’s gross misconduct) or reduction in hours of the covered employee’s employment;

(iii) the divorce or legal separation of the covered Employee from such covered Employee’s Spouse;

(iv) the covered Employee becoming entitled to benefits under Title XVIII of the Social
Security Act (Medicare);

(v) a dependent child who ceases to be a dependent child under the terms of this Plan.

(vi) the Employer's filing for Chapter 11 reorganization as it would affect retiree coverage.

G. "University/College" means an accredited institution listed in the current publication of accredited institutions of higher education.

Section 7

MISCELLANEOUS

7.1 Amendment and Termination. The Employer may amend or terminate this Plan at any time by action of the Board. The Employer may amend or modify this Plan retroactively to enable the Plan to provide non-taxable medical expense reimbursement benefits under section 105 of the Code. No amendment shall deprive any Participant or beneficiary of any benefit to which he or she is entitled under this Plan with respect to contributions previously made, and no amendment shall provide for the use of funds or assets other than for the benefit of Employees and their beneficiaries, except as may be specifically authorized by statute or regulation.

7.2 Effect of Plan on Employment. The Plan shall not be deemed to constitute a contract of employment between the Participating 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 Participating 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 will have upon him or her as a Participant of this Plan.

7.3 Alienation of Benefits. No benefit under this Plan may be voluntarily or involuntarily assigned or alienated, except as provided pursuant to a Qualified Medical Child Support Order pursuant to Section 609 of ERISA and Section 7.4 hereof.

7.4 Qualified Medical Child Support Orders. The Plan Administrator shall adhere to the terms of any medical child support order that satisfies the requirements of this Section 7.4 and Section 609 of ERISA. A medical child support order is any judgment, decree or order (including approval of a property settlement agreement) issued by a court of competent jurisdiction which (i) relates to the provision of child support with respect to the child of a Participant under a group health plan (including this Plan) or provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to such benefit under such group health plan, or (ii) enforces a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, and which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to receive benefits payable with respect to a Participant or beneficiary under a group health plan. For purposes of this Section, an "alternate recipient" shall mean any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.

Any such medical child support order must clearly specify the name and last known mailing
address of the Participant and the name and mailing address of each alternate recipient covered by the order, a reasonable description of the type of coverage to be provided under the group health plan to each such alternate recipient, or the manner in which such type of coverage is to be determined, the period to which such order applies, and each plan to which such order applies.

Any such medical child support shall not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13623 of the Omnibus Budget Reconciliation Act of 1986). The Plan Administrator shall promptly notify the Participant and each alternate recipient of the receipt of a medical child support order by the Plan and the Plan's procedures for determining the qualified status of medical child support orders. Within a reasonable period after receipt of a medical child support order, the Plan Administrator shall determine whether such order is a

7.11 Heirs and Assigns. This Plan shall be binding upon the heirs, executors, administrators, successors and assigns of all parties, including each Participant and beneficiary.

7.12 Headings and Captions. The headings and captions set forth in the Plan are provided for convenience only, shall not be considered part of the Plan, and shall not be employed in construction of the Plan.

7.13 Gender and Form. Unless the context clearly indicates otherwise, pronouns shall be interpreted so that the masculine pronoun shall include the feminine, and the singular shall include the plural.

7.14 Tax Effects. Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether or not any payments received by a Participant hereunder will be treated as includible in gross income for federal or state income tax purposes.

7.15 Multiple Functions. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

7.16 Terms. The primary meaning of terms set forth in this Plan shall be as defined in Section 1 (Definitions). However, if a term used herein is not set forth in Definitions the meaning given to that term shall be the same as provided for in the Cafeteria Plan.

7.17 Source of Payments. The Employer shall be the sole source of Benefits under the Plan. No Employee or beneficiary shall have any right to, or interest in, any assets of the Company upon termination of employment or otherwise, except as provided from time to time under the Plan, and then only to the extent of the Benefits payable under the Plan to such Employee or beneficiary.

Executed this sixth day of November, 2003

Pension Funds, Inc.

By: __________________________________________________________________________

Executive Secretary

ATTEST: _______________________________________________________________________

Chairperson