UT FLEX PLAN DOCUMENT

AS AMENDED AND RESTATED

EFFECTIVE JANUARY 1, 2026

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INTRODUCTION

The Board of Regents of the University of Texas System (the Board) has adopted this flexible compensation, non-deferred compensation plan, hereinafter referred to as the "Plan," pursuant to Texas Insurance Code Section 1601.152 to recognize contributions made to the Plan by its Employees. The Board has delegated the authority to the Chancellor, pursuant to Regent's *Rules and Regulations,* Series 30202, Section 3 to administer the Plan. Pursuant to Section 3.01, *id,* the Chancellor has provided for the planning, implementation, management, and administration of the employee group insurance, health benefit programs and the UTFLEX plan through such U. T. System committees and administrators, namely the Executive Vice Chancellor for Business Affairs and the University of Texas System Administration Office of Employee Benefits.

The purpose of the plan is to provide compensation alternatives for those Employees and their beneficiaries who shall qualify hereunder and to permit Participants to choose from among several types of benefits. These choices shall include an option to receive certain tax-free benefits in lieu of taxable compensation. The cash option benefit available under the Plan will be treated as taxable compensation to the Participants. Other available benefits are intended to qualify as statutory non-taxable fringe benefits.

Texas Insurance Code Section 1601.003(3) requires that the Plan qualify and be construed as a "Cafeteria Plan" within the meaning of Section 125(d) of the Internal Revenue Code of 1986 (the Code). It is the intent of The University of Texas System that the benefits which an Employee elects to receive under the Plan be eligible for exclusion from such Employee's gross income to the extent provided by the Code and the Plan complies with the applicable provisions of the Code.

Although this Plan is a "Cafeteria Plan" and has been reduced to writing in order to comply with Code Section 125, the Plan shall also serve as an amendment to certain welfare plans presently in effect for the University of Texas System. Thus, to the extent necessary, this legal instrument will serve as an amendment to each of said welfare plans in order to permit the benefits of this Plan to be fully implemented for Participants.

The Plan will not discriminate in favor of highly compensated individuals to the extent prohibited by Code Section 125.

ARTICLE I
DEFINITIONS

As used in this Flex Plan, the following words and phrases have the meanings set forth below unless the context clearly indicates otherwise, and wherever appropriate the singular shall include the plural, the plural shall include the singular, and the use of any gender shall include the other gender.

Section 1.01 Account means a record keeping account established by the Plan Administrator in the name of each Participant for the purpose of accounting for contributions made thereto by and on behalf of a Participant and benefits paid for a Participant.

Section 1.02 Code means the Internal Revenue Code of 1986, as amended from time to time as well as any regulation adopted by the Internal Revenue Service to implement the Code. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

Section 1.03 Compensation means a Participant's basic salary including amounts that would otherwise qualify as compensation but are not received directly by the Participant pursuant to a good faith, voluntary, written salary reduction agreement in order to finance payments to a deferred compensation or tax sheltered annuity program specifically authorized by state law or to finance benefit options under this Flex Finn, plus, longevity and hazardous duty pay and including non-monetary compensation, the value of which is determined by The University of Texas System, but excluding overtime pay. The term "Compensation" also includes the state paid employee portion of FICA (social security).

Section 1.04 Dependent means a "qualifying child" or "qualifying relative" as defined in Code Section 152 as modified by Code Section 105(b). For purposes of health care reimbursements under the Medical or Medical-Related Expense Reimbursement Benefits of the Plan, "qualifying relative" is not subject to the income limitation of Code Section 152. For purposes of the Dependent Care Assistance benefits of the Plan, "Dependent" means any individual who is (a) a "qualifying child" of the Participant who is under the age of 13 and who resides with the Participant for more than one-half of the year, or (b) a Dependent or the Spouse of the. Participant who is physically or mentally incapable of caring for himself or herself, meets any income limitation of "qualifying relative" of Code Section 152 and shares the same principal place of abode with the Participant.

Section 1.05 Dependent Care Reimbursement Plan means a separate flexible spending account plan under Section 129 of the Code designed to provide payment or reimbursement for dependent care expenses as described in Article VI hereof.

Section 1.06 Dependent Care Reimbursement Plan Administrator means a vendor that qualifies as a carrier for purposes of Texas Insurance Code Section 1601.005 and with which The University of Texas contracts to administer the Dependent Care Reimbursement Plan unless the Plan Administrator is to directly administer the Health Care Reimbursement Plan, in which case the term shall mean the Plan Administrator.

Section 1.07 Eligible Employee means an Employee of the. Employer who has satisfied the conditions for eligibility to participate in the Flex Plan in accordance with Article II hereof and, to the extent necessary, an individual other than an Employee who is entitled to benefit payments under the Flex Plan.

Section 1.08 Employee means a person rendering services to The University of Texas System, its universities, colleges, and departments for compensation which is subject to federal income tax withholding and FICA laws.

Section 1.09 Employer means The University of Texas System, its universities, colleges, and departments.

Section 1.10 Entry Date means the first day of the Plan Year except for an Employee who first satisfies the requirements for eligibility during the Plan Year, including rehired Employees in which case, the Entry Date shall be the first day of the month coincident with or next following the satisfaction of the requirements for eligibility in accordance with Article II hereof.

Section 1.11 Flex Plan means the UTFLEX Employee Benefit Plan established pursuant to the laws of the State of Texas and by means of this document, any and all exhibits or documents which are incorporated and made a part hereof by reference, including separate written plans of the University of Texas System and any amendments which may be made to the Flex Plan from time to time.

Section 1.12 Flexible Benefit Dollars means the dollars available to a Participant through the Salary Conversion Agreement or from the Employer which may be used for purposes of purchasing benefits under the FLEX Plan.

Section 1.13 Health Care Reimbursement Plan means a separate flexible health care spending account plan under Sections 105(b) and 106 of the Code, designed to provide medical care expense reimbursement as described in Article VII hereof.

Section 1.14 Health Care Reimbursement Plan Administrator means a vendor that qualifies as a carrier for purposes of Texas Insurance Code Section 1601.005 and with which The University of Texas contracts to administer the Health Care Reimbursement Plan unless the Plan Administrator is to directly administer the Dependent Care Reimbursement Plan, in which case the term shall mean.

Section 1.15 Health Coverage means the employee group health coverage offered under the Plan. Unless clearly stated otherwise, it does not include dental, vision or any other coverages.

Section 1.16 Incurred or to Incur for purposes of the Plan an expense is considered to be incurred on the date at which the service is provided, regardless of the date of payment of or billing for the expense.

Section 1.17 Insurance Premium Redirection Plan means a separate plan under Sections 105(b) and 106 of the Code designed to provide insurance premium redirection as described in Article VIII hereof.

Section 1.18 Participant means an Eligible Employee who has elected to participate in the Flex Plan for a Period of Coverage, who has not ceased to be an Employee or become ineligible for participation.

Section 1.19 Period of Coverage means the Plan Year during which coverage of benefits under the Flex Plan is available to and elected by a Participant. Provided, however, an Employee who becomes eligible to participate during a Period of Coverage may elect to participate for a period lasting until the end of the current Period of Coverage. In such case, the interval commencing on such Employee's Entry Date and ending as of the last day of the current Period of Coverage shall be deemed to be such Participant's Period of CoverageSection 1.20 Plan Administrator means such U. T. System committees and/or administrators as the Chancellor deems appropriate to provide for the planning, implementation, management, and administration of the employee group insurance and health benefit programs of The University of Texas System. If no such committee or administrator is designated, the Plan Administrator means The University of Texas System.

Section 1.21 Plan Year means a twelve (12) month period commencing September 1 of each year and ending August 31 of the following year.

Section 1.22 Salary Conversion Agreement means a written agreement by and between the Employer and Participant under which the Employer during the Plan year reduces the Participant's salary and contributes the amount of the reduction to the Plan on behalf of the Participant, as a before-tax contribution.

Section 1.23 Spouse means an individual married to a person of the same sex or opposite sex if they were lawfully married in this state, or any state whose laws authorize the marriage of two individuals of the opposite or same sex.

Section 1.24 Statutory Nontaxable Benefit means a benefit provided to a Participant under the Flex Plan which is not includable in the Participant's gross income by reason of a specific provision in the Code and is permissible under the Flex Plan in accordance with Section 125 of the Code.

ARTICLE II
ELIGIBILITY FOR PARTICIPATION

Section 2.01 Requirements for Eligibility: An Employee eligible to participate in The University of Texas System group insurance program established pursuant to Texas Insurance Code Chapter 1601 shall be eligible to participate in the Flex Plan.

Section 2.02 Application for Participation: Any Employee who enrolls or is enrolled in an insurance plan offered by or through UT System pursuant to Texas Insurance Code Chapter 1601 is automatically enrolled as a participant in the Insurance Premium Redirection Plan. Once an Employee satisfies the requirements for eligibility, the Employer shall furnish to such Eligible

Employee information regarding the Plan, including available benefits hereunder. An Employee wishing to participate in the Health Care Reimbursement Plan or the Dependent Care Reimbursement Plan shall also be required to furnish to the Employer a signed, completed UT Flex Salary Conversion Agreement, either in writing or electronically, along with such information and documentation as may be deemed necessary by the Employer for proper administration of the Flex Plan.

An Employee upon becoming a Participant shall be deemed to have consented to and be bound by all the terms, conditions, and limitations of the Plan, any and all amendments hereto, any administrative rules adopted by the Plan Administrator, and any decisions or determinations made by the Plan Administrator with respect to the Participant's rights and entitlement to benefits under the Plan.

Section 2.03 Termination of Participation: A Participant will cease participation in the Plan for purposes of making a salary deduction as of the earliest of the following events: the last day of the month of the date of termination of employment with the Employer, the date on which the Participant ceases to be eligible to participate hereunder, or the date of termination of the Plan.

Section 2.04 Continuation of Coverage: The Plan provides continuation of health coverage for each Benefit made available under Article III that is considered to be a "group health plan" under Code Section 5000(b)(1) because Employees and their Dependents are provided with health care benefits within the meaning of Code Section 213(d)(1) (including the Medical or Medical-Related Expense Reimbursement Benefit), as said coverage changes from time to time, to qualified beneficiaries who would lose coverage under the Plan by reason of a qualifying event and who elect such coverage and pay the full premium for such coverage as determined by the Employer. Election of such coverage shall be made within the election period specified in Code Section 4980B. Said coverage shall' continue for the period of coverage specified in Code Section 4980B. For purposes of this paragraph, the terms "continuation coverage," "qualified beneficiaries" and "qualifying event" shall have the same meaning as set forth in Code Section 4980B.

Section 2.05 FMLA Leaves of Absence: If a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), to the extent required by the FMLA, the Employer will continue to maintain the Participant's Medical and Dental Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant was still active (that is, the Employer will continue to pay its share of the premium to the extent the Participant opts to continue coverage). The Employer may elect to continue all Medical and Dental Insurance Benefits and Health Care Reimbursement Account coverage for Participants while they are on paid leave (so long as Participants on non- FMLA paid leave are required to continue coverage). If so, the Participant will pay their share of the premiums by the method normally used during any paid leave (for example, on a pre-tax salary reduction basis if that is what was used before the FMLA leave began).

If the Participant is going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), and the Participant opts to continue their Medical and Dental Insurance Benefits and Health Care Reimbursement Account, then the Participant may pay their share of the premium:

(a) with after-tax dollars while on leave; or

(b) with pre-tax dollars to the extent the Participant receives compensation during the leave on a pre-tax salary reduction basis out of pre-leave compensation, including unused sick days and vacation days, or

If the Participant's Medical or Dental Insurance Benefits or Health Care Reimbursement Account Benefits ceases while on FMLA leave (e.g., for non-payment of required contributions), the Participant will be entitled to re-enter such Benefits, as applicable, upon return from such leave on the same basis as they were participating in the Plan before the leave, or otherwise required by the FMLA. The Participant is entitled to have coverage for such Benefits automatically so long as coverage for Employees on non-FMLA leave is automatically reinstated upon return from leave. However, with regard to. Health Care Reimbursement Account Benefits, if the Participant's coverage ceased he or she will be entitled to elect whether to be reinstated in the Health Care Reimbursement Account Benefits coverage at the same coverage level as in effect before the FMLA leave (with increased contributions for the remaining period of coverage) or at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not pay premium. If the Participant elects the pro-rata coverage; the amount withheld from their compensation on a payroll-by-payroll basis for the purpose of paying for reinstated Medical. Expense Reimbursement Account Benefits will equal the amount withheld before FMLA leave.

If the Participant is commencing or returning from FMLA leave, the election for non-medical or dental benefits (such as Group Term Life Insurance, AD&D and Long Term Disability Insurance Benefits and Dependent Care Reimbursement Account Benefits) will be treated in the same way as under the Employer's policy for providing such Benefits for Participants on a non-FMLA leave. Participants may discontinue contributions while on leave and upon returning from leave be required to repay the premiums not paid by the participant during leave. Payment will be withheld from the Participant's compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

Section 2.06 Non-FMLA Leaves of Absence: If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant may continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Plan. Administrator. If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 4.04 will apply. To the extent post-employment continuation such as COBRA applies, the Participant may continue coverage under those terms.

ARTICLE III
BENEFITS

Section 3.01 Benefits Available for Selection by Participant: A Participant may elect or be enrolled in, in accordance with the procedure set forth in Section 4, one or more of the following benefits:

(a) Dependent care reimbursement pursuant to the Dependent Care Reimbursement Plan adopted by The University of Texas System, as set forth in Article VI hereof. Participants may elect benefits under such Dependent Care Reimbursement Plan subject to all the requirements and conditions contained therein;

(b) Medical expense reimbursement pursuant to the Health Care Reimbursement Plan adopted by The University of Texas System, as set forth in Article VII hereof. Participants may elect benefits under such Health Care Reimbursement Plan, subject to all the requirements and conditions contained therein; and

(c) Insurance premium redirection pursuant to the Insurance Premium Redirection Plan adopted by The University of Texas System, as set forth in Article VIII hereof. Participants are automatically enrolled for the Insurance Premium Redirection Plan, subject to all the requirements and conditions contained therein, unless enrollment in such Plan is waived. Such enrollment will automatically be renewed each Plan year.

Section 3.02 Reference to Other Documents: To the extent any optional benefits described in Section 3.01 are provided under insurance contracts with an insurance carrier, certificates of coverage, or by a separate written plan or contract, such contract, certificate, or separate written plan are hereby incorporated by reference and made a part hereof as fully as if copied verbatim herein.

ARTICLE IV
BENEFIT ELECTION AND FLEXIBLE BENEFIT DOLLARS

Section 4.01 Election of Flexible Savings Account Benefits and Salary Conversion Agreement: An Eligible Employee:

(a) May elect under this Flex Plan, prior to the first day of an applicable Period of Coverage, coverage under Article III, Sections 3.01(a) and (b) hereof. Such election shall be made at the time and in the manner specified by the Plan Administrator, pursuant to uniform and nondiscriminatory rules as set forth in applicable federal law and regulations as amended from time to time consistently applied for such elections. The Employer shall provide to Eligible Employees, prior to an applicable Period of Coverage, the necessary electronic or hard copy election forms for electing such coverage, which shall include a Salary Conversion Agreement whereby the Participant shall agree to a reduction in Compensation equal to the Participants share of the cost of each optional benefit selected under Section 3.01 (a) or (b). The Eligible Employee shall be required to sign and return the election form in the time and in the manner required by the Plan Administrator. Prior to the due date for the next ensuing Period of Coverage, a Participant shall elect optional benefits in Article III, Sections 3.01(a) and (b) and execute a Salary Conversion Agreement. The failure of a Participant to elect these benefits and submit the required forms shall be deemed an express election to waive participation.

(b) Is automatically enrolled in coverage under Article III, Section 3.1(c) upon election of any coverage provided through the UT System Group Insurance Program established by Texas Insurance Code Chapter 1601 to which the Employee must contribute a portion of the premium and shall be deemed to have agreed to deduction of Salary Conversion Dollars in the amount of such premium.

Section 4.02 Effect of Change in Cost of Benefits: There shall be an automatic adjustment in the amount of Salary Conversion Dollars (as defined in Section 8.02 hereof) used to purchase optional benefits through the Insurance Premium Redirection Plan in the event of change, for whatever reason, during an applicable Period of Coverage of the cost of providing such optional benefits to the extent permitted by applicable law and regulations. The automatic adjustment shall be equal to the increase (or decrease) in such cost. A Participant shall be deemed by virtue of participation in the Insurance Premium Redirection Plan to have consented to this automatic adjustment.

Section 4.03 Payment of Flexible Benefit Dollars: Flexible Benefit Dollars shall be remitted by the Employer to the Plan Administrator in an amount equal to the Participant's reduction in Compensation pursuant to the Salary Conversion Agreement.

To the extent a Participant has elected coverage for which premium is paid through the Insurance Premium Redirection Plan described in Article VIII hereof, Flexible Benefit Dollars shall be forwarded for such benefits provided under such Plans, which shall be governed by the terms, conditions, and limitations set forth therein, for purposes of purchase of benefits at such time and in such manner as determined in accordance with the terms and provisions of such contract or contracts representing such benefits of this Plan.

To the extent a Participant has elected coverage under the Dependent Care Reimbursement Plan described in Article VI hereof, Flexible Benefit Dollars shall be forwarded to the Dependent Care Plan Administrator for deposit in the Participant's Dependent Care Reimbursement Account, and to the extent that a Participant has elected coverage under the Health Care Reimbursement Plan described in Article VII hereof, Flexible Benefit Dollars shall be forwarded to the Health Care Reimbursement Plan Administrator for deposit in the Participant's Health Care Reimbursement Account in accordance with the terms of said Plans, and payment or reimbursement of such Flexible Benefit Dollars.

Section 4.04 Benefit Election Irrevocable: A Participant's election under this Plan is irrevocable for the duration of the Plan Year to which it relates. In other words, unless one of the exceptions set forth in this Section applies, the Participant may not change any elections for the duration of the Plan Year regarding:

- Participation in this Plan;
- Salary reduction amounts; or
- Election of particular component plan benefits.

A Participant entitled to make a new election under this Section 4.04 must do so within 31 days of the event. An Employee who is eligible to elect benefits but declined to do so during the initial election period, or during a subsequent annual enrollment period, may file a pretax

contribution election change within 31 days of the occurrence of an event described in this section, but only if the election under the new salary reduction agreement is made on account of and corresponds with the event. Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly adopted Dependent child pursuant to a special enrollment right may be retroactive for up to 31 days. All other new elections shall be effective prospectively immediately following the date the Participant files the new Salary Conversion Agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.

The exceptions to the irrevocability requirement are as follows:

(a) Change in Status is any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued under Code §125 that the Plan Administrator (in its sole discretion) decides to recognize on a uniform and consistent basis:

(i) Legal Marital Status: A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(ii) Number of Dependents: Events that change a Participant's number of Dependents (as defined in Code Section 152), including birth, death, adoption, and placement;

(iii) Chance in Employment Status: Any change in employment status of the Participant, the Participant's Spouse or the Participant's Dependents that affects the benefit eligibility under a cafeteria plan or other employee benefit plan of the employer of the Participant, the Spouse, or Dependents, such as: termination or commencement of employment, a commencement of or return from an unpaid leave of absence, a change in worksite, switching from salaried to hourly-paid or vice versa, incurring a reduction or increase in hours of employment (e.g., going from part-time to full-time), or any other similar change which makes the individual become (or cease to be) eligible for a particular employee benefit;

(iv) Dependent Eligibility Requirements: An event that causes a Participant's Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as due to attaining a specified age, getting married, or ceasing to be a student; and

(v) Change in Residence: A change in the place of residence of the Participant, the Participant's Spouse or the Participant's Dependent.

(b) Special Enrollment Rights: If a Participant, a Participant's Spouse or a Participant's Dependent is entitled to special enrollment rights under a group health plan, as required by Code §9801(f), and medical coverage was declined under the group health plan because of outside medical coverage and eligibility for such coverage

is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or if a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, then a Participant may revoke a prior election for health or accident coverage and make a new election (including salary reduction election), provided that the election corresponds with such special enrollment right. For purposes of this provision, (1) an election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right; and (2) a special enrollment election attributable to the birth or adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 90 days).

(c) Certain Judgments, Decrees and Orders: If a judgment, decree, or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's Dependent child (including a foster child who is a Dependent of the Participant), a Participant may: (i) change his or her election to provide coverage. for the Dependent child (provided that the order requires the Participant to provide coverage); or (ii) change his or her election to revoke coverage for the Dependent child if the order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan provided other coverage is actually procured.

(d) Medicare and Medicaid: If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health or accident benefit under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled. to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the. Participant may prospectively elect to commence or increase the health or accident coverage.

(e) Change in Cost: (These rules do not apply to Health Care Reimbursement accounts under Article VII).

(i) Automatic Increase or Decrease for Insignificant Cost Changes. If the cost of a Benefit Plan or Policy increases or decreases during a Plan Year by an insignificant amount, then the Pretax Contributions or After-tax Contributions (as applicable) under each affected Participant's election shall be prospectively increased or decreased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective increase or decrease in affected employees' elective contributions in accordance with such cost changes. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases or decreases in costs are

"insignificant" based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change).

(ii) Significant Cost Increases/Decreases. If the Plan Administrator determines that the cost of a Participant's Benefit Plan(s) or Policy(ies) significantly increases during a Plan Year, the Participant may either make a corresponding prospective increase in his or her contributions, or revoke his or her election, and in lieu thereof, receive coverage under another Plan option which provides similar coverage, or can drop coverage if no similar coverage is available. If the Plan Administrator determines that the cost of a Participant's Benefit Plan(s) or Policy(ies) significantly decreases during a Plan Year, the Participant may revoke his or her election, and in lieu thereof, receive coverage under the decreased Plan option which provides similar coverage. In the event of a decrease, Participants who were not previously enrolled could elect the decreased Plan option. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and what constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(iii) Limitation on Change in Cost Provisions for Dependent Care Expense Reimbursement. The above "Change in Cost" provisions apply to Dependent Care Expense Reimbursement *only* if the cost change is imposed by a dependent care provider who is not a "relative" of the employee by blood or marriage (as that term is defined in Proposed Treas. Reg. §1.125-4(f)(2)(iii) or other IRS guidance).

(f) Change in Coverage: (*The rules in Subparagraphs i, ii, and iv do not apply to Health Care Reimbursement accounts under Article VII*).

(i) Significant Curtailment. If the Plan Administrator determines that a Participant's Benefit Plan or Policy coverage under this Plan is significantly curtailed during a Plan Year, the Participant may revoke his or her election under the Plan. In that case, each affected Participant may prospectively elect coverage under another Benefit Plan or Policy option which provides similar coverage but cannot drop coverage. If the Plan Administrator determines that a Participant Benefit Plan or Policy coverage under this Plan is significantly curtailed that results in a loss of coverage, the Participant may elect coverage under another Benefit Plan or Policy option that provides similar coverage, or can drop coverage if no other similar option is available. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided to Participants under the Plan so as to constitute reduced coverage to Participants in general. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a substitute Benefit Plan or Policy

constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(ii) Addition or Significant Improvement of Benefit Package Option. If, during a Plan Year, the Plan adds a benefit or significantly improves an existing benefit plan, an affected Participant may revoke his or her election and make a new election on a prospective basis for coverage under the new or improved benefit plan, Participants who previously waived coverage may elect to participate in the new or improved benefit plan. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether there has been a "significant improvement" in a benefit plan.

(iii) Change in Coverage of Spouse or Dependent Under Their Employer's Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under any employer plan (including the plan or the Spouse's, former spouse's, or Dependent's employer), so long as (a) the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its participants to make an election change that would be permitted under IRS regulations; or (b) the Plan permits Participants to make an election for a Plan Year period of coverage which is different from the plan year period of coverage under the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's or Dependent's employer. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the Spouse's, former Spouse's, or Dependent's employer.

(iv) Special Open Enrollment Rights following Loss of Coverage under a Medicaid or Children's Health Insurance Plans. (*The rules set forth in this Subparagraph iv do not apply to Dependent Reimbursement Expense accounts under Article VII or Health Care Reimbursement accounts under Article VII*.) Participants or Dependents who are eligible under an Employer's group health plan but not enrolled, shall be eligible to enroll for coverage within 60 days after:

(A) the Participant's or Dependent's coverage under a Medicaid plan or under a state children's health insurance program is terminated as a result of loss of eligibility for such coverage loss of coverage under a Medicaid or Children's Health Insurance Plan (CHIP) plan; or

(B) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the Employer's group health plan.

Election changes made pursuant to this Subparagraph iv shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change and shall be effective on a prospective basis only.

(g) Certain Clerical Errors: An erroneous election that was clearly caused by a clerical error made during the enrollment redirection election process may be corrected only if reported by the Participant within 31 days of receipt of the first payroll check that contains the UT FLEX election error to the Plan Administrator. The report must be in writing and include clear and convincing evidence that the mistake was an inadvertent clerical error. The Plan Administrator shall have exclusive authority to determine whether a change in benefit election meets the criteria hereunder. All such determinations are final. The Plan Administrator may take any steps permissible under the Plan to correct the error but will not allow any changes in the election that were not created by the error.

(h) Reduction in Hours, Health Coverage: A Plan Participant who was expected to work on average at least 30 hours per week is then expected midyear to work on average less than 30 hours per week, the Participant may drop the Plan's Health Coverage, even if the reduction in hours does not result in the Participants loss of eligibility under the health plan. The change in election must correspond to the Participant's intended enrollment, and the intended enrollment of any Dependents whose coverage is being dropped, in other Minimum Essential Coverage as defined in §5000A(f)(1) of the Patient Protection and Affordable of Care Act (PPACA), including another group health plan or a State Health Insurance Exchange established under § 1311 of PPACA (an "Exchange"). The new coverage must be effective no later than the first day of the second month following the month in which the Plan Health Coverage is dropped. In allowing such a change, the Plan Administrator will rely on a Participant's reasonable representation about his or her intended enrollment. This exception does not permit a participant to drop coverage in the Health Care Reimbursement Plan.

(i) Revocation of Health Coverage Due to Enrollment in a Qualified Health Plan: A Participant who is eligible to enroll in a Qualified Health Plan through Exchange coverage, during an Exchange open enrollment or special enrollment period may drop Plan's Health Coverage midyear. The change must correspond to the Participant's intended enrollment, and the intended enrollment of any Dependents whose coverage is being dropped, in Exchange coverage that is effective no later than the clay after the last day of the Plan coverage. In allowing such a change, the Plan Administrator will rely on a Participant's reasonable representation about his or her intended enrollment. This exception does not permit a Participant to drop coverage in the Health Care Reimbursement Plan.

Section 4.05 Funding: All benefits accruing under the Plan with respect to an Employee shall be payable solely out of the general assets of such Employee's Employer. The Employer shall have no obligation to establish a trust or fund for the payment of benefits under this Flex Plan or

to insure any of the benefits under this Plan. The Employer shall have no obligation to pay interest on any amounts used to purchase coverage under this Plan, or any plan that is a part thereof.

Section 4.06 Salary Reduction: By participating in the Plan, each Participant agrees to have his or her annual Compensation reduced by the Participant's cost of the premium for which he is responsible to pay for Benefits selected by him under the Plan and for a Participant electing to participate in the Health Care Reimbursement Plan and/or the Dependent Care Reimbursement Plan, an executed Salary Conversion Agreement.

Section 4.07 Prohibited Deposits: Participants shall not be permitted to deposit their own after-tax dollars into any Plan account except to the extent specifically provided herein.

ARTICLE V
NONDISCRIMINATION

Section 5.01 Code and Regulations Followed: This Flex Plan, the benefits provided hereunder, or contributions made hereto, shall be in compliance with the Code and applicable regulations promulgated there under, regarding nondiscrimination, eligibility, and regarding plan qualification requirements.

Section 5.02 Provisions to Prevent Discrimination: In the event the Plan Administrator determines at any point in time that any discrimination described under any applicable provision of the Code regarding discrimination may occur, the Plan Administrator shall be authorized to cause the election made by any Participant to be modified to the extent necessary to avoid or cure such discrimination. Such Participants participating herein shall be deemed, upon executing the requisite application for participation, to have expressly consented to any modifications of the application and Salary Conversion Agreement deemed necessary by the Plan Administrator to prevent discrimination from occurring.

Section 5.03 Nondiscrimination Not Guaranteed: Neither the Employer, the Plan Administrator nor any agent or representative thereof, represents that this Flex Plan, the benefits provided hereunder, or contributions made hereto, are at any particular point in time nondiscriminatory as determined in accordance with the Code and applicable regulations promulgated there under. The Employer, the Plan Administrator, and any agent or representative thereof shall be held harmless by any Employee, Participant, their representatives, heirs, beneficiaries, administrators, or assigns from any and all tax liability of any nature that might arise by reason of the Flex Plan being deemed discriminatory at any time and in any regard or by reason of plan qualification requirements.

Section 5.04 Inclusion in Income: In the event any portion or all of a benefit or benefits becomes taxable hereunder, by reason of the Flex Plan being deemed discriminatory, such benefit shall be treated as received or accrued in the taxable year of the Participant in which the Plan Year ends unless applicable law requires inclusion in income at some other point in time, in which case, such law shall be controlling.

ARTICLE VI
DEPENDENT CARE REIMBURSEMENT PLAN

Section 6.01 Introduction: Pursuant to this Article, the Employer establishes the UTFLEX Dependent Care Reimbursement Plan (the "Dependent Care Reimbursement Plan") under which a Participant may elect to have payments made or receive reimbursement for Dependent Care Expenses which are excludable from gross income. The Dependent Care Reimbursement Plan is intended to be qualified under Section 129 of the Code, and to satisfy all requirements necessary for it to provide a nontaxable benefit under the Flex Plan and represents one benefit which may be elected under the Flex Plan. This Dependent Care Reimbursement Plan constitutes a separate written employee benefit plan as contemplated by Section 129(d) (1) of the Code. The Dependent Care Reimbursement Plan shall be construed consistently with the provisions of Sections 125 and 129 of the Code.

The Plan Administrator may contract with a Dependent Care Reimbursement Plan Administrator to administer the Plan under the direction of the Plan Administrator. The Plan Administrator shall at all times ensure that the Dependent Care Reimbursement Plan is administered in a manner consistent with the terms and provisions hereof, in a uniform and nondiscriminatory manner, and in accordance with the Code and applicable regulations promulgated there under.

Section 6.02 Definitions: Unless otherwise defined herein, terms shall have the meanings set forth in the Flex Plan. For purposes of this Dependent Care Reimbursement Plan, the following special definitions shall apply:

(a) Dependent - means a "qualifying child" or "qualifying relative" as defined in Code Section 152 as modified by Code Section 105(b) For purposes of the Dependent Care Assistance benefits of the Plan, "Dependent" means any individual who is (a) a "qualifying child" of the Participant who is under the age of 13 and who resides with the Participant for more than one-half of the year, or (b) a Dependent or the Spouse of the Participant who is physically or mentally incapable of caring for himself or herself, meets any income limitation of "qualifying relative" of Code Section 152 and shares the same principal place of abode with the Participant.

(b) Dependent Care Assistance - within the meaning of Code Section 129, shall mean household and employment-related services and expenses. Household services and expenses are those for the care of a Qualifying Individual within the meaning of Code Section 21(b)(1) which are performed to enable a Participant to remain gainfully employed and which are performed (a) in the home of the Participant; (b) outside the home of Participant for the care of the Participant's Dependents under the age of 13; (c) outside the home of Participant for a Qualifying Individual described above, who regularly spends at least eight (8) hours a day in the Participant's home; or (d) outside the home of Participant for the care of a Qualifying Individual as described above, and in a Dependent Care Center; the term "Dependent Care Center" shall have the same meaning as set out in Code Section 21(b)(2)(D). Employment related expenses are those which are considered employment-related under Code Section 21(b)(2).

(c) Dependent Care Reimbursement. Account - means the bookkeeping account maintained by the Plan Administrator or the Dependent Care Plan. Administrator used for crediting contributions hereto and accounting for benefit payments here from. See also Section 6.07.

(d) Dependent Care Service Provider - means a person who provides care or other services described in Section 6.02(b) above, but shall not include (i) a dependent care center (as defined in Section 21(b) (2) (D) of the Code) unless the requirements of Section 21(b) (2) (C) of the Code are satisfied, or (ii) a related individual described in Section 129(c) of the Code.

(e) Earned Income - means an individual's wages, salaries, tips and other employee compensation, plus the amount of the individual's net earnings from self-employment during the Plan Year, computed without regard to any community property laws, without taking into account any amount received as a pension or annuity, without taking into account any amount to which Code Section 871(a) applies, and without taking into account any amounts paid under this Dependent Care Reimbursement Plan or paid under a dependent care assistance plan of any other employer.

(f) Full-Time Student - means an individual who during each of at least five months during the taxable year is a full-time student at an educational organization described in Code Section 170(b)(1)(A)(ii). The individual must enroll for the number of course hours considered to constitute full-time study and may not attend exclusively at night.

(g) Grace Period - means a specific period, not to exceed the fifteenth (15^{th}) day of the third calendar month after the end of the immediately preceding plan year to which it relates during which unused benefits or contributions may be paid or reimbursed for the particular qualified benefit for which the contribution was made, and may not be cashed out or converted to any other taxable or non-taxable benefit available under the Plan as permitted by IRS Notice 2005-42 and the Code.

(h) Participant - means an Eligible Employee who has elected to participate in the Dependent Care Reimbursement Plan in accordance with Section 6.03.

(i) Period of Coverage - means the Plan Year, plus any Grace Period that may be established by the Plan Administrator, during which coverage of benefits under the Dependent Care Reimbursement Plan is available to and elected by a Participant, except for purposes of an Employee first eligible to participate in the Dependent Care Reimbursement Plan, or a rehired Employee eligible to participate in the Dependent Care Reimbursement Plan, in which event, the initial Period of Coverage shall commence on such Participants Entry Date and end on the last day of the Plan Year. For example, the 2019-2020 Plan Year, the Period of Coverage ends August 31, 2021. For the 2020-2021 Plan Year, the Period of Coverage ends August 31, 2022.

(j) Qualifying Individual - within the meaning, provided in Code Section 21(b)(1) means:

(i) a Dependent of a Participant as defined in Code Section 152 and who is under the age of 13;

(ii) a Dependent or the Spouse of a Participant who is physically or mentally incapable of caring for himself, meets any income limitation of "qualifying relative" under Code Section 152(to the extent required by Code Section 21(b)(1)), and has the same place of abode as the Participant.

(k) Salary Conversion Agreement - means a written or electronic agreement, by and between the Employer and Participant, entered into prior to an applicable Period of Coverage in which the Participant agrees to a reduction in Compensation for purposes of payment or reimbursement of Dependent Care Expenses. If a participation fee is imposed for participation in the Plan, the Agreement may be construed to also authorize the Employer to withhold such fees from the Participant's Compensation beginning with the pay period coincident with the first date upon which the Agreement takes effect.

(l) Salary Conversion Dollars - means the dollars credited to the Participant's Dependent Care Reimbursement Account in an amount equal to the amount by which the Participants Compensation is reduced pursuant to a Salary Conversion Agreement.

Section 6.03 Requirements for Eligibility: An Employee eligible to participate under the Flex Plan shall be eligible to participate in the benefits of this Dependent Care Reimbursement Plan upon submission of the election form and Salary Conversion Agreement described in Section 4.01 of Article IV thereof. The terms for enrollment and termination under the Flex Plan shall constitute the terms for enrollment and termination under this Dependent Care Reimbursement Plan.

Section 6.04 Maximum Salary Reduction: Subject to any limitations imposed by federal law, the maximum amount which a Participant may elect to receive in any calendar year in the form of Dependent Care Expenses under this Dependent Care Reimbursement Plan, shall be the lesser of (a) the Participant's Earned Income for the calendar year (after all reductions in compensation including the reduction related to Dependent Care Expenses), (b) the Earned Income of the Participant's Spouse for the calendar year, (If the Participant is married at the end of such calendar year), or (c) the amounts allowed by Code Section 129 and related regulations, for example ($5,000 for the 2025-2026 Plan Year ($7,500 for the 2026-2027 Plan Year) ($2,500 in the case of a married individual who files a separate income tax return for the 2025-2026 Plan Year ($3,750 for the 2026-2027 Plan Year)), in the case of either (a) or (b) less dependent care benefits paid by the Spouse's employer. In the case of a Participant's Spouse who is a Full-Time Student at an educational institution or is a Qualifying Dependent, such Spouse shall be deemed to have Earned Income of not less than $250 per month if the Participant has one Dependent and $500 per month if the Participant has two or more Dependents in accordance with Section 21(d)(2) of the Code.

Section 6.05 Code and Regulations Followed: This Dependent Care Reimbursement Plan, the benefits provided hereunder, or contributions made hereto, shall be in compliance with the Code and applicable regulations promulgated there under, regarding nondiscrimination, eligibility, and regarding plan qualification requirements.

Section 6.06 Reduction of Benefits: The Plan Administrator may reduce amounts of benefits payable to a Participant to the extent the Plan Administrator deems necessary to assure that the Dependent Care Reimbursement Plan is nondiscriminatory and in compliance with the Code and applicable regulations promulgated there under. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this Section shall be forfeited and be available to pay administration expenses of the Dependent Care Reimbursement Plan.

A Participant shall be deemed, upon executing the requisite application for participation, to have expressly consented to any modifications of the application and Salary Conversion Agreement deemed necessary by the Plan Administrator to comply with the limitations specified herein.

Section 6.07 Dependent Care Reimbursement Account: The Plan Administrator shall require the Dependent Care Plan Administrator to establish for each Participant a Dependent Care Reimbursement Account for each Period of Coverage. Each Dependent Care Reimbursement Account shall initially contain Zero Dollars ($0). A Participant's Dependent Care Reimbursement Account for a Period of Coverage shall be credited with the portion of the Participant's Salary Conversion Dollars that may be accrued from month to month for that Period of Coverage pursuant to the Salary Conversion Agreement. A Participant's Dependent Care Reimbursement Account for that Period of Coverage shall be reduced by the amount of any Dependent Care Expenses paid to or on behalf of a Participant.

Section 6.08 Claims for Reimbursement: A Participant shall apply in writing or electronically for reimbursement of claims using the forms provided by the Dependent Care Reimbursement Plan Administrator. The Dependent Care Reimbursement Plan Administrator may require the Participant to provide additional information and complete appropriate documents or forms for the proper administration of a claim. The Dependent Care Reimbursement Plan Administrator will process the Participants claim form(s), compute benefits due and issue a payment, if appropriate, to the Participant. The Plan Administrator shall make all determinations of expense eligibility and fund availability, based on the Participant's Dependent Care Reimbursement Account available balance(s) under the Plan. Such determination will be made no later than 30 days after receipt of the claim form, except in special circumstances (such as the need to obtain further information) but in no case more than 60 days after the receipt of the claim.

Section 6.09 Reimbursement or Payment of Dependent Care Expenses: Subject to limitations contained in this Article, the Dependent Care Plan Administrator shall reimburse the Participant from the Participant's Dependent Care Reimbursement Account for Dependent Care Expenses incurred during the Period of Coverage, for which the Participant submits documentation, in accordance with Section 6.08.

No reimbursement or payment of Dependent Care Expenses Incurred during a Period of Coverage shall exceed the specified Plan year contributory rate. No reimbursement or payment of Dependent Care Expenses incurred during a Period of Coverage shall at any time exceed the balance of the Participant's Dependent Care Reimbursement Account at the time of the reimbursement or payment. The amount of any Dependent Care Expenses not reimbursed or paid as a result of the preceding sentence during a Period of Coverage, shall be reimbursed or paid only if and when the balance in such Dependent Care Reimbursement Account permits such reimbursement or payment. Any overpayment shall be refunded immediately upon demand. Payment of Dependent Care Assistance shall be made by Employer only to the extent that such amounts have not been previously claimed as a credit by Participant or reimbursed pursuant to another plan or policy.

Participants shall be reimbursed for such Dependent Care Expenses on a basis to be determined by the Plan Administrator. Payment of benefits for any Period of Coverage may be made following the close of such Period of Coverage based on accepted claims filed with the Plan Administrator by November 30 following the close of such Period of Coverage.

If a Participant ceases to be a Participant or terminates employment, such Participant shall be entitled to continue receiving benefits pursuant to this Article to the extent of the amount remaining in the Participant's Dependent Care Reimbursement Account for expenses incurred during the Period of Coverage. A Participant may not receive reimbursements under this Dependent Care Reimbursement Plan for any expenses Incurred after the Period of Coverage or for which reimbursement is not requested prior to November 30 next following the end of the Plan Year in which termination of employment occurred.

Section 6.10 Forfeiture of Unused Benefits: Amounts remaining in a Participant's Dependent Care Reimbursement Account, following final payment of all Dependent Care Expenses incurred during the applicable Period of Coverage, or after November 30 following the close of the Plan Year, shall be forfeited and be available to pay administrative expenses of the Dependent Care Reimbursement Plan. To the extent such forfeited funds exceed administrative expenses of the Dependent Care Reimbursement Plan, they may be used to:

(a) Offset reasonable administrative expenses of the Plan;

(b) Reduce future Participant contributions to the Plan on a uniform and nondiscriminatory basis.

Section 6.11 Report to Participants: On or before January 31 of each calendar year, or at such other time as may be specified by applicable law and regulation, the Plan Administrator shall furnish to each Participant who has received dependent care assistance during the prior calendar year, a written statement showing the amount of such assistance paid during such year with respect to the Participant.

Section 6.12 Administration: The Dependent Care Reimbursement Plan shall be administered by the Dependent Care Plan Administrator on behalf of the Plan Administrator who shall have the powers and duties set forth in Section 9.03 of the Flex Plan, as amended or supplemented from time to time.

Section 6.13 Other Governing Provisions: Other matters not specifically addressed in this Dependent Care Reimbursement Plan, including but not limited to contributions, elections, claims procedures, amendment of the Dependent Care Reimbursement Plan, and termination of the. Dependent Care Reimbursement Plan, shall be governed by the provisions of the Flex Plan which are incorporated herein by reference.

Section 6.14 Intent: This Plan and the benefits provided by this Article VI are intended to comply with the provisions of Code Sections 105 and 106 and, therefore, will be deemed to be automatically amended to comply with all appropriate regulations to these parts, issued by any appropriate government agency as of the effective date of each such regulation, unless the Employer instead elects to terminate the Plan following issuance of new regulations.

ARTICLE VII
HEALTH CARE REIMBURSEMENT PLAN

Section 7.01 Introduction: Pursuant to this Article, the Employer establishes the UTFLEX Health Care Reimbursement Plan (the "Health Care Reimbursement Plan") under which a Participant may elect to receive payments or reimbursements of eligible medical expenses which are excludable from gross income. The Health Care Reimbursement Plan is intended to be qualified under Sections 105 and 106 of the Code, and to satisfy all requirements necessary for it to provide a nontaxable benefit under the Flex Plan, and represents one benefit which may be elected under the Flex Plan. This Health Care Reimbursement Plan constitutes a separate written employee benefit plan as contemplated by Section 105(b) of the Code and Treasury Regulation Section 1.105-11(b). The Health Care Reimbursement Plan shall be construed consistently with the provisions of Sections 105(b), 105(e), 105(h) and 106 of the Code. The Plan Administrator may offer an optional Debit Card Program to Participants. The Plan Administrator may assess a fee to Participants who elect the Debit Card Program option to cover the cost of the program.

The Plan Administrator may contract with a Health Care Reimbursement Plan Administrator to administer the Plan under the direction of the Plan Administrator. The Plan Administrator shall at all times ensure that the Health Care Reimbursement Plan is administered in a manner consistent with the terms and provisions hereof in a uniform and nondiscriminatory manner and in accordance with the Code and applicable regulations promulgated thereunder.

Section 7.02 Definitions: For purposes of this Health Care Reimbursement Plan, the following special definitions shall apply:

(a) Debit Card Program - means use of a stored-value card ("Debit Card") which electronically accesses and debits the Participant's Health Care Reimbursement Account when an eligible expense is incurred.

(b) Dependent - means a "qualifying child" or "qualifying relative" as defined in Code Section 152 as modified by Code Section 105(b). For purposes of health care reimbursements under the Medical or Medical-Related Expense Reimbursement Benefits of the Plan, "qualifying relative" is not subject to the income limitation of Code Section 152.

(c) Grace Period - means a specified period not to exceed the fifteenth (15^{th}) day of the third calendar month after the end of the immediately preceding plan year to which it relates during which unused benefits or contributions may be paid or reimbursed for the particular qualified benefit for which the contribution was made, and may not be cashed out or converted to any other taxable or non-taxable benefit available under the Plan as permitted by IRS Notice 2005-42 and the Code.

(d) Medical or Medical Related Expenses - means any expenses Incurred by a Participant or Dependent of such Participant for medical care as described in Section 213 of the Code including, but not limited to, amounts paid for hospital bills, medical, drug, dental, vision services, and effective January 1, 2020, over-the-counter drugs and medicines without a prescription, but only to the extent that the Participant or other person Incurring the expense is not reimbursed for the expense through any insurance policy, whether the premium on such policy is paid by the Employer or the individual Participant, or (ii) not provided for or reimbursable under any other plan or policy (other than under the Health Care Reimbursement Plan).

(e) Medical or Medical-Related Expense Reimbursement - means the payments by the Employer to reimburse Participants for medical or medical-related expenses to the extent provided for in the Participant's signed Salary Conversion Agreement. Such payments shall be for expenses Incurred by a Participant, or by the Spouse or Dependent of such Participant, for medical care as defined in Section 213(d) of the Code (including amounts paid for hospital bills, medical, drug, dental bills, and effective January 1, 2020, over-the-counter drugs and medicines without a prescription). Expenses are reimbursed only to the extent that the Participant or other person Incurring the expense is not reimbursed and will not seek to be reimbursed for the expense through insurance or otherwise (other than under the Plan). In cases where both the Participant and the Participant's Spouse are Participants, only one of the Participants will be reimbursed for any individual expense.

(f) Health Care Reimbursement Account - means the account maintained by the Plan Administrator or the Health Care Reimbursement Plan Administrator used for crediting contributions hereto and accounting for benefit payments here from. See also Section 7.07.

(g) Over-the-Counter, or OTC, Claims - means claims for drugs and medicines purchased by a Participant or a Participant's Spouse or Dependent without a physician prescription for the Participant's or a Spouse's or Dependent's medical care which are excludable from gross income under Section 105 of the Code.

(h) Participant - means an Eligible Employee who has elected to participate in the Health Care Reimbursement Plan in accordance with Section 7.03.

(i) Period of Coverage - means the Plan Year, plus any Grace Period established by the Plan Administrator, during which coverage of benefits under the Health Care

Reimbursement Plan is available to and elected by a Participant, except for purposes of an employee first eligible to participate in the Health Care Reimbursement Plan, or a rehired Employee eligible to participate in the Health Care Reimbursement Plan, in which event, the initial Period of Coverage shall commence on such Participant's Entry Date and end on the last day of the Plan Year.

(j) Salary Conversion Agreement or "Agreement" - means a written agreement by and between the Employer and Participant entered into prior to an applicable Period of Coverage in which the Participant agrees to a reduction in Compensation, for purposes of reimbursement for or payment of Medical Care Expenses. If a participation fee is imposed for participation in the Plan and/or the Debit Card Program, the Agreement may be construed to also authorize the Employer to withhold such fees from the Participant's Compensation beginning with the pay period that Agreement takes effect.

(k) Salary Conversion Dollars - means the dollars credited to the Participant's Health Care Reimbursement Account in an amount equal to the amount by which the Participant's Compensation is reduced pursuant to a Salary Conversion Agreement.

Section 7.03 Requirements for Eligibility: An Employee eligible to participate under the Flex Plan shall be eligible to participate in this Health Care Reimbursement Plan. The terms of enrollment and termination for the Flex Plan shall constitute the terms of enrollment and termination under this Health Care Reimbursement Plan.

Section 7.04 Maximum Salary Reduction: Subject to the limitations set forth herein to avoid discrimination, the maximum amount of Flexible Benefit Dollars which a Participant may elect to receive in any Plan Year beginning on or after September 1, 2013, for Medical Care Expenses under this Article shall be that which is allowed by Code Section 125(i). For the 2025-2026 tax year that amount is $3,300.

Section 7.05 Code and Regulations Followed: This Health Care Reimbursement Plan, the benefits provided hereunder, or contributions made hereto, shall be in compliance with the Code and applicable regulations promulgated thereunder, regarding nondiscrimination, eligibility, and regarding plan qualification requirements.

Section 7.06 Reduction of Benefits: The Plan Administrator may reduce amounts of benefits payable to a Participant to the extent the Plan Administrator deems necessary to assure that the Health Care Reimbursement Plan is nondiscriminatory in compliance with the Code and applicable regulations promulgated thereunder. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this Section shall be forfeited and be available to pay administration expenses of the Health Care Reimbursement Plan.

A Participant shall be deemed, upon executing the requisite application for participation, to have expressly consented to any modifications of the application and Salary Conversion

Agreement deemed necessary by the Plan Administrator to comply with the limitations specified herein.

Section 7.07 Health Care Reimbursement Account: The Plan Administrator shall establish for each Participant a Health Care Reimbursement Account for each Period of Coverage. Each Health Care Reimbursement Account shall initially contain Zero Dollars ($0). A Participant's Health Care Reimbursement Account for a Period of Coverage shall be increased by the portion of the Participant's Salary Conversion Dollars that may be accrued from month to month for that Period of Coverage pursuant to a Salary Conversion Agreement. A Participant's Health Care Reimbursement Account for a Period of Coverage shall be reduced by the amount of any Medical Care Expenses paid to or on behalf of a Participant.

Section 7.08 Claims for Reimbursement: A Participant shall apply in writing or electronically for reimbursement of claims using the forms provided by the Health Care Reimbursement Plan Administrator or if the Participant has elected to participate in the Debit Card Program, use of the Debit Card. The Health Care Reimbursement Plan Administrator may require the Participant to provide additional information and complete appropriate documents or forms for the proper administration of a claim. The Health Care Reimbursement Plan Administrator will process the Participant's claim, compute benefits due and issue a payment, if appropriate, to the Participant. The Health Care Reimbursement Plan Administrator shall make all determinations of expense eligibility and fund availability, based on the Participant's Health Care Reimbursement Account available balance(s) under the Plan. Such determination will be made no later than 30 days after receipt of the claim form, except in special circumstances (such as the need to obtain further information) but in no case more than 60 days after the receipt of the claim. If the Participant has elected to participate in the Debit Card Program, the card payment is conditional, and the Participant may have to submit appropriate documentation to determine the eligibility of the expense.

Section 7.09 Reimbursement of Medical Care Expense: Subject to limitations contained in other provisions of the Health Care Reimbursement Plan, the Health Care Reimbursement Plan Administrator shall reimburse the Participant, from the Participant's Health Care Reimbursement Account, for Medical Care Expenses Incurred during the Period of Coverage for which the Participant files a claim in accordance with Section 7.08. No reimbursement or payment of Medical Care Expenses Incurred during a Period of Coverage shall exceed the specified Plan Year contributory rate; however, the amount elected to be contributed for the full period of coverage under the Health Care Reimbursement Account is available at all times during the Period of Coverage, reduced for all prior reimbursements for the same Period of Coverage. Participants shall be reimbursed for Medical Care Expenses on a basis to be determined by the Plan Administrator; provided, however, that the final payment of benefits for any Period of Coverage may be made following the close of such Period of Coverage, based on accepted claims filed, by November 30 following the close of the Plan Year. Any overpayment shall be refunded immediately upon demand.

If a Participant terminates employment, the Participant shall be eligible to continue the required premium payments during the current. Period of Coverage in the manner prescribed by the Plan Administrator. If a Participant ceases to be a Participant or terminates employment, such Participant shall be entitled to continue receiving benefits pursuant to this Article to the extent of

the amount remaining in the Participants Health Care Reimbursement Account for the expenses incurred (i) during the Period of Coverage, and (ii) prior to termination of employment, if the employee does not continue to make the required premium payments.

Section 7.10 Debit Card Program: By enrolling in the Debit Card Program, a Participant agrees to pay any fees, agrees to repay overpayment and ineligible payments, and certifies that (i) the Debit Card is used only for an eligible expense under the Health Care Reimbursement Plan; (ii) any expense paid with the Debit Card has not been reimbursed and the Participant will not seek reimbursement under any other plan; (iii) the Participant will acquire and retain sufficient documentation for all expense paid with the Debit Card; and (iv) each use of the Debit Card by the Participant constitutes a recertification of this certification.

Any approved transaction by Participant involving a Debit Card is subject to adjudication by the Health Care Reimbursement Plan Administrator. The Debit Card may provide for instant adjudications of reimbursements for medical, dental, vision, and prescription co-pays and recurring reimbursements that have been previously approved. For a claim that does not correlate to a co-payment under the plan or a recurring reimbursement that has been previously approved, a third party may substantiate a claim through an electronic process at the point of sale.

All OTC claims submitted will be audited and require production of itemized receipts that identify the merchant name, item purchased, date and amount of the cash register receipt. The Program will limit quantities for any OTC claims to predetermined amounts.

The Debit Card may not be used for the Dependent Care Spending Account. The Health Care Reimbursement Plan Administrator will take specific steps, including request for repayment, withholding, and claim offset, to recover any ineligible payments or overpayments. The Debit Card may be suspended or cancelled immediately upon notification by Health Care Reimbursement Plan Administrator or the Employer.

Participants may also pay for eligible medical expenses from their account by submitting a reimbursement of claims form to the Health Care Reimbursement Plan Administrator.

Section 7.11 Forfeiture of Unused Benefits: Amounts remaining in a Participant's Health Care Reimbursement Account, following final payment of all Medical Care Expenses incurred during the applicable Period of Coverage, shall be forfeited and be available to pay, administrative expenses of the Health Care Reimbursement Plan. To the extent such forfeited funds exceed administrative expenses of the Health Care Reimbursement Plan, they may be used to:

(a) Offset reasonable administrative expenses of the Plan;

(b) Reduce future Participant contributions to the Plan on a uniform and nondiscriminatory basis.

Section 7.12 Administration: The Health Care Reimbursement Plan shall be administered by the Health Care Reimbursement Plan Administrator on behalf of the Plan Administrator. The Plan Administrator shall have the powers and duties set forth in Section 9.03 of the Flex Plan, as amended or supplemented from time to time.

Section 7.13 Other Governing Provisions: Other matters not specifically addressed in this Health Care Reimbursement Plan, including but not limited to contributions, elections, claims procedures, amendment of the Health Care Reimbursement Plan and termination of the Health Care Reimbursement Plan, shall be governed by the provisions of the Flex Plan incorporated herein by reference.

Section 7.14 Intent: This Plan and the benefits provided by this Article VII are intended to comply with the provisions of Code Sections 105 and 106 and, therefore, will be deemed to be automatically amended to comply with all appropriate regulations to these parts, issued by any appropriate government agency as of the effective date of each such regulation, unless the Employer instead elects to terminate the Plan following issuance of new regulations

Section 7.15 Qualified Reservist Distributions: Notwithstanding anything in this Health Care Medical Reimbursement Plan to the contrary or this Flex Plan to the contrary, the Health Care Reimbursement Plan may provide "qualified reservist distributions" as provided in the HEART Act of 2008. In accordance with the HEART Act, such Qualified Reservist Distributions are subject to the following requirements:

(a) Eligibility. Qualified reservist distributions are available to any Participant who is a member of a "reserve component" as defined in section 101 of title 37 of the United States Code who, by reason of being a member of a reserve component, has been ordered or called into active duty for (i) 180 days or more or (ii) an indefinite period ("Reservist").

(b) Timing. Qualified reservist distributions must be requested during the period beginning on the date the Reservist is ordered or called into active duty ("Call-Up Date") and ending on the last day of the Plan Year including the Grace Period. The request must be made on forms and following procedures established by the Plan Administrator and must include a copy of the order or call to duty. Qualified reservist distributions will be made no later than 60 days after request.

(c) Maximum Distribution. Qualified reservist distributions may not exceed the amounts contributed to qualified reservists Health Care Reimbursement account less the amount of Health Care Reimbursement Account Benefits received by the Reservist up to the date of the Qualified Reservist. Distribution.

ARTICLE VIII
INSURANCE PREMIUM PREDIRECTION PLAN

Section 8.01 Introduction: Pursuant to this Article, the Employer establishes the UTFLEX Insurance Premium Redirection Plan (the "Insurance Premium Redirection Plan") under which a Participant pays, unless he or she has otherwise elected out of the insurance premium redirection plan, certain insurance premiums with Salary Conversion Dollars rather than after-tax dollars. The Insurance Premium Redirection Plan is intended to be qualified under Sections 105 and 106 of the Code, and to satisfy all requirements necessary for it to provide a nontaxable benefit under the Flex Plan and represents one benefit under the Flex Plan. This Insurance Premium Redirection Plan constitutes a separate written employee benefit plan as contemplated by Section

105(b) of the Code and Treasury Regulation Section 1.105-11(b). The Insurance Premium Redirection Plan shall be construed consistently with the provisions of Sections 125 and 129 of the Code.

The Plan Administrator shall at all times administer the Insurance Premium Redirection Plan in a manner consistent with the tenets and provisions hereof in a uniform and nondiscriminatory manner and in accordance with the Code and applicable regulations promulgated there under.

Section 8.02 Definitions: For purposes of this Insurance Premium Redirection Plan, the following special definitions shall apply:

(a) Dependent - means a Participant's Spouse or any individual who qualifies as a Dependent of the Participant under Section 152 of the Code, taking into account Section 105(b) of the Code.

(b) Insurance Premium Expenses - means any expenses incurred by a Participant, or by a Spouse or Dependent of such Participant, as payment for the amount of insurance premium expense that exceeds the employer contribution offered as an employee benefit by the Employer. The types of insurance covered by this Insurance Premium Redirection Plan include basic group term life insurance not exceeding $50,000, Health Coverage (medical and prescription coverage), dental, vision care and accidental death and dismemberment. Employer provided voluntary group-term life insurance, long term care, long term disability and short teen disability insurance are not covered by this Insurance Premium Reduction Plan.

(c) Insurance Premium Redirection Account - means the bookkeeping account maintained by the Plan Administrator or its designee used for crediting contributions hereto and accounting for benefit payments here from. See also Section 8.07. The account may also be used to account for premium contributions made on behalf of the Participant by the Employer, from Employer or appropriated funds.

(d) Participant - means an Eligible Employee who has elected to participate in accordance with Section 8.03.

(e) Period of Coverage - means the Plan Year during which coverage of benefits under the Insurance Premium Redirection. Plan is available to and elected by a Participant, except for purposes of an Employee first eligible to participate in the Insurance Premium Redirection Plan or a rehired Employee eligible to participate in the Insurance Premium Redirection Plan, in which event, the initial Period of Coverage shall commence on such Participant's Entry Date and end on the last day of the Plan Year.

(f) Salary Conversion Dollars - means the dollars credited to the Participant's Insurance Premium Redirection Account in an amount equal to the amount by which the Participants Compensation is reduced pursuant to the Participant's

coverage elections resulting in the Insurance Premium Expenses owed by the Participant.

Section 8.03 Requirements for Eligibility: An Employee eligible to participate under the Flex Plan shall be eligible to participate in the benefits of this Insurance Premium Redirection Plan if such Employee is participating in The University of Texas System insurance program by completing the appropriate election form, typically through the online enrollment system.

Section 8.04 Maximum Salary Reduction: Subject to the limitations set forth herein as provided by federal law, as amended from time to time, to avoid discrimination, the maximum amount of Flexible Benefit Dollars which a Participant may elect to receive in any Plan Year for Insurance Premium Expenses under this Article shall be the amount required to pay the Participants portion of the premiums for coverage under each type of insurance the Employer selects for inclusion in this Insurance Premium Redirection Plan.

Section 8.05 Code and Revelations Followed: This Insurance Premium Redirection Plan, the benefits provided hereunder, or contributions made hereto, shall be in compliance with the Code and applicable regulations promulgated there under, regarding nondiscrimination, eligibility, and regarding plan qualification requirements.

Section 8.06 Reduction of Benefits: The Plan Administrator may reduce amounts of benefits payable to a Participant to the extent the Plan Administrator deems necessary, to assure that the Insurance Premium Redirection Plan is nondiscriminatory in compliance with the Code and applicable regulations promulgated there under. Any such reduction of benefits shall be made by the Plan Administrator on a reasonable and nondiscriminatory basis. Contributions which may not be paid out because of benefit reductions imposed by this Section shall be forfeited and be available to pay administration expenses of the Insurance Premium Redirection Plan.

Section 8.07 Insurance Premium Redirection Account: The Plan Administrator or its designee shall establish for each Participant a bookkeeping account that tracks Insurance Premium Redirection contributions for each Period of Coverage. Each Insurance Premium Redirection Account shall initially contain Zero Dollars ($0) in. Insurance Premium Redirection contributions. A Participants Insurance Premium Redirection Account for a Period of Coverage shall be increased by the portion of the Participant's Salary Conversion Dollars that may be accrued from month to month for that Period of Coverage pursuant to the elections made by the Participant resulting in the Insurance Premium Expenses owed by the Participant. A Participant's Insurance Premium Redirection Account for a Period of Coverage shall be reduced by the amount of any specified Insurance Premium Expenses paid to or on behalf of a Participant.

Section 8.08 Claims for Reimbursement: A Participant shall be considered to have applied to the Plan Administrator for payment of Insurance Premium Expenses incurred by the Participant during the Period of Coverage. No other application for payment of benefits shall be required of the Participant.

Section 8.09 Payment of Insurance Premium Expense: Subject to limitations contained in other provisions of the Insurance Premium Redirection Plan, the Plan Administrator shall use the balance accumulated in the Participant's Insurance Premium Redirection Account to pay the

Insurance Premium Expenses incurred during the Period of Coverage. The Plan Administrator shall pay any such Insurance Premium Expenses directly to the provider of such insurance coverage in lieu of reimbursing the Participant for this expense. The maximum amount to be deducted through the Participants Salary Conversion Agreement will equal the amount required to be contributed by the Participant to receive coverage under each type of insurance the Employer selects for inclusion in this Insurance Premium Redirection Plan that the Participant has elected for the Period of Coverage.

Section 8.10 Forfeiture of Unused Benefits: If there exist amounts remaining in a Participant's Insurance Premium Redirection Account, following final payment of all Insurance Premium Expenses incurred during the applicable Period of Coverage, such amounts shall be forfeited and made available to pay administration expenses of the Insurance Premium Redirection Plan. Any overpayment made by the Plan Administrator shall be refunded immediately upon demand.

Section 8.11 Administration: The Insurance Premium Redirection Plan shall be administered by the Plan Administrator who shall have the powers and duties set forth in Section 9.03 of the Flex Plan as amended or supplemented from time to time.

Section 8.12 Other Governing Provisions: Other matters not specifically addressed in this Insurance Premium Redirection Plan, including but not limited to contributions, elections, claims procedures, amendment of the Insurance Premium Redirection Plan, and termination of the Insurance Premium Redirection Plan, shall be governed by the provisions of the Flex Plan incorporated herein by reference.

Section 8.13 Intent: This Plan and the benefits provided by this Article VIII are intended to comply with the provisions of Code Sections 105 and 106 and, therefore, will be deemed to be automatically amended to comply with all appropriate regulations to these parts, issued by any appropriate government agency as of the effective date of each such regulation, unless the Employer instead elects to terminate the Plan following issuance of new regulations.

ARTICLE IX
PLAN ADMINISTRATION

Section 9.01 Plan Administrator: The administration of the Flex Plan and the plans that are a part thereof (the "Plans"), as provided herein, including the payment of all benefits to Participants or their beneficiaries, shall be the responsibility of the Plan Administrator.

Section 9.02 Records and Reports of the Plan Administrator: The Plan Administrator shall keep such written records as it shall deem necessary or proper.

Section 9.03 Administrative Powers and Duties: The Plan Administrator shall have the power to take all actions required to carry out the provisions of the Plans and shall further have the following powers and duties which shall be exercised in a manner consistent with the provisions of the Plans:

(a) To construe and interpret the provisions of the Plans and make rules and regulations under the Plans to the extent deemed advisable and to construe and interpret the document according to current and amended federal law;

(b) To decide all questions as to eligibility to become a Participant in the Plans pursuant to applicable state and federal law or regulation and to the rights of Participants under the Plans;

(c) To file or cause to be filed all such annual reports, returns, schedules, descriptions, financial statements, and other information as may be required by any federal or state law or regulation, agency, or authority;

(d) To obtain from Employers and Employees such information as shall be necessary for the proper administration of the Plans;

(e) To determine the amount, manner, and time of payment of benefits hereunder;

(f) To communicate to any insurer or other contract supplier of benefits under the Plans in writing all information required to carry out the provisions of the Plans;

(g) To prepare and distribute information explaining the Plans to Participants and notify the Participants of the Plans in writing of amendments or termination of the Plans or of a change in any benefits available under the Plans within a reasonable period of time;

(h) To prescribe such procedures and forms as may be required for Eligible Employees to make elections under the Plans;

(i) To do such other acts as the Plan Administrator deems necessary to administer the Plans in accordance with the provisions hereof, or as may be provided for or required by law and regulation; and

(j) To appoint individuals, committees, or organizations to assist in the administration of the Plans and to engage any agents or consultants it deems advisable, including legal and actuarial counsel.

Section 9.04 Claims:

(a) Notice of Claim: In the event a Participant has a claim for any benefits under the Plans, such Participant shall file a claim with the Plan Administrator, on a form or fowls provided for such purpose by the Plan Administrator, which shall be available at the Employer's designated office. If the Participant fails to file a claim for benefits, then the Plan Administrator may take whatever steps are necessary and proper to dispose of the Participant's potential benefits under the Plans and shall be held harmless in performance of same. Prior to making any payment of benefits hereunder, the Plan Administrator may require the Participant to provide such information and to complete any appropriate documents or forms necessary for the proper administration of the Plans, including filing of all appropriate claims and

requests for payment from any other plan or plans maintained by the Employer or other person or entity. The Plan Administrator shall make all determinations as to the right of any Participant to a benefit under these Plans.

(b) Availability of Plan Information and Documents: Any Participant who has a question concerning the operation of the Plans of the Participant's eligibility for the payment of benefits under the Plans, shall contact the Plan Administrator, either in person or in writing.

Section 9.05 Taxation: It is the intent of this Plan to be in compliance with Code Sections 79, 105, 106, 120, 125, 129 and 137 and thereby is entitled to deduct the amount paid for the benefits provided under Section 4980E of the Code. However, this Plan has not been submitted to the Internal Revenue Service, and there is no assurance that the intended tax benefit under this Plan will be available.

Neither The University of Texas System or its designated representative or agent makes any commitment or guarantee that any amounts elected or paid for the benefit of a Participant 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 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. It is further understood that the Employer and its representative or agent shall be held harmless if the Participant should neglect to do so.

Any Participant, by accepting a benefit under this Plan, agrees to be liable for any tax penalties and interest which may be imposed by the Internal Revenue Service with respect to these benefits. If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold Federal or State income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

Section 9.06 HIPAA Privacy and Security Rule Compliance: The plan shall maintain, use and disclose Protected Health Information (PHI) to the extent of and in accordance with the maintenance, uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the federal regulations adopted there under or any other applicable federal privacy and security laws and regulations. Specifically, the Plan will use and disclose PHI in accordance with the Privacy and Security Policies adopted by The University of Texas System Administration in accordance with HIPAA.

ARTICLE X
AMENDMENT AND TERMINATION

Section 10.01 Amendment of Plans: The Board of Regents or its designee may amend any or all provisions of any of the Plans at any time, by written instrument identified as an amendment of such Plan, effective as of a date specified therein.

Section 10.02 Termination of Plans: The Plans are intended to be permanent; however, any of them may be terminated by the Board of Regents if the Board of Regents determines that such Plan is no longer advantageous to the Employer's Employees. In such case, the Board of Regents may adopt an order terminating such Plan, and providing a procedure for the orderly withdrawal of the Employer and its Employees from such Plan.

Section 10.03 Preservation of Rights: Termination or amendment of the Plans shall not affect the rights of any Participant in his or her Accounts or the right to claim reimbursement for expenses incurred prior to such termination or agreement, as the case may be, to the extent such amount is payable under the terms of the Plans, prior to the effective date of such termination or amendment.

ARTICLE XI
MISCELLANEOUS

Section 11.01 Facility of Payment: If the Plan Administrator deems any person entitled to receive any amount under the provisions of any of the Plans, incapable of receiving or disbursing same by reason of minority, illness or infirmity, mental incompetence, death or incapacity of any kind, the Plan Administrator may, in its discretion, take any one or more of the following actions:

(a) Apply such amount directly for the comfort, support, and maintenance of such person;

(b) Reimburse any person for any such support theretofore supplied to the person entitled to receive any such payment; and

(c) Pay such amount to a legal representative or guardian, or any other person selected by the Plan Administrator, for such comfort, support, and maintenance, including without limitation, any relative who has undertaken, wholly or partially, the expense of such person's comfort, care, and maintenance, or any institution in whose care or custody the person entitled to the amount may be that a court of competent jurisdiction may designate.

The Participant shall hold harmless the Plan Administrator; its agents, servants, and employees and the Employer from any harm or damage due to the payment of any amounts paid in accordance with the provisions of this Section.

Section 11.02 Lost Payee: Any amount due and payable to Participant or beneficiary shall be forfeited if the Plan Administrator, after reasonable effort, is unable to locate the Participant or beneficiary to whom payment is due.

Section 11.03 Plan Not a Contract of Employment: Nothing contained in these Plans shall be construed as a contract of employment between the Employer and any Employee or Participant, or as a right of any Employee or Participant to be continued in the employment of the Employer, or as a limitation of the right of the Employer to discharge any Employee or Participant with or without cause.

Section 11.04 No Rights to Employer's Assets: No Employee, Participant, Dependent, or beneficiary of an Employee or Participant, or their heirs, successors, or assigns shall have any right to, or interest in, any assets of the Employer, upon termination of a Participants employment or otherwise, except as provided from time to time under these Plans, and then only to the extent of the benefits payable under these Plans to such Employee, Participant, Dependent, or beneficiary.

Section 11.05 Non-Alienation of Benefits: Benefits payable under these Plans shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any such liability which is for alimony or other payments for the support of a Spouse or former Spouse, or for any other relative of the Employee, prior to actually being received by the person entitled to the benefit under the terms of the Plans; and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, or otherwise dispose of any right to benefits payable hereunder, shall be void. Neither the Employer nor the Plan Administrator shall in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements, or torts of any person entitled to benefits hereunder.

Section 11.06 Severability: If any provision of the Plans, including instruments incorporated herein by reference, shall be held illegal, invalid, or disqualifying for any reason, said illegality or invalidity shall not affect the remaining provisions hereof with such illegal, invalid, or disqualifying provision being fully severable from the contents of the Plans, and the Plans shall be construed and enforced as if such illegal, invalid, or disqualifying provision had not been included herein.

Section 11.07 Titles, Heading and Genders: The headings of the Plans have been inserted for ease of reference only and are not to be interpreted as part of the construction of the provisions hereof. References in the Plans to one gender shall include both genders and singular references shall include the plural unless the context clearly requires otherwise.

Section 11.08 Governing Law: The provisions of the Plans shall be construed according to the laws of the State of Texas, except as superseded by federal law, and in accordance with the Code and applicable regulations promulgated there under to the extent such law or regulation applies to the Plans, and rules promulgated by the Plan Administrator. The Flex Plan is intended to be a cafeteria plan under Section 125(d) of the Code containing a medical expense reimbursement plan under Sections 105 and 106 of the Code, a dependent care assistance program under Section 129 of the Code and a premium redirection plan and shall be construed accordingly.

Section 11.09 Benefits Provided Through Third Parties: In the case of any benefit or service provided through a third party, such as an insurance company or plan administrator, pursuant to a contract or policy with such third party, if there is any conflict or inconsistency between the description of benefits contained in this Plan and such contract or policy, the terms of such contract or policy shall control.

Section 11.10 Multiple Copies: Any copy, scanned image, or similarly reproduced copy of this Amended Flex Plan Document shall also be deemed an original for all purposes.

Section 11.11 Effective Date: The effective date of the Flex Plan as amended by this Restated and Amended Flex Plan document shall be January 1, 2026, except that the effective date of any amendments to this plan, necessitated by a change in state or federal law shall be the date that the state or federal law requiring the change takes effect.

SIGNED ON BEHALF OF THE UNIVERSITY OF TEXAS SYSTEM BOARD OF REGENTS

By: _____
John Zerwas
Chancellor

Date: _____