8.6 Records and Reports. The Committee shall keep a record of all actions taken and shall keep all other books of account, records and other data that may be necessary for the proper administration of the Plan. The Committee shall be responsible for supplying all information and reports to the IRS, Department of Labor, Members, Beneficiaries and others, as required by law; provided, however, that reports concerning distributions, whether to a governmental agency or a recipient, shall be the responsibility of the Trustee.

8.7 Information from Employer. The Employer shall furnish to the Trustee proper written evidence of the names of the individuals duly appointed to the Committee, and of any resignations, deaths, removals or replacements of Committee members. To enable the Committee to perform its functions, the Employer shall provide full and timely information to the Committee on all matters relating to each Member's compensation, hours of service, years of service, retirement, death, disability or termination of employment, and such other pertinent facts and data as the Committee may require. The Committee shall advise the Trustee of the foregoing facts as may be pertinent to the Trustee's duties under the Plan. The Committee and Trustee may rely upon such information as is provided by the Employer and shall have no duty or responsibility to verify such information.

8.8 Payment of Expenses. Any bond required by applicable law for the performance of duties by Committee members, as well as all reasonable and necessary costs, expenses and liabilities incurred by the Committee in the supervision and administration of the Plan, that are not paid by the Employer, shall be a charge against the Plan assets and shall be paid therefrom (from forfeitures under the Plan or otherwise) by the Trustee, as directed in writing by the Committee. All Plan administration expenses may be paid from Plan assets (from forfeitures under the Plan or otherwise), unless paid by the Employer. Such expenses shall include any expenses incident to the functioning of the Committee, including but not limited to, fees of accountants, counsel and other specialists, and other costs of administering the Plan. Until paid, the expenses shall constitute a liability of the Plan assets. However, the Employer may reimburse the Trust for any administrative expenses incurred under this Section 8.8 or otherwise under the Plan.

8.9 Discretion. The Committee shall discharge its duties with respect to the Plan in the sole interest of the Members and their Beneficiaries, using the care, skill and discretion that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character under then prevailing circumstances. The Committee, in communicating the funding policy to the Trustee and any Investment Manager appointed under the Plan, shall instruct them to diversify the investments of the Trust so as to minimize the risk of large losses, unless it is clearly prudent under the circumstances not to do so.

8.10 Liability of Committee. No member of the Committee shall be liable for any act or omission on his own part, or on the part of any other Committee member, the Trustee, an Investment Manager or any other Fiduciary or agent appointed to serve the Plan, except to the extent required by law and to the extent that liability cannot be waived.

8.11 Employer Liability. The Employer assumes no obligation or responsibility with respect to any Employee, Member or Beneficiary for any act of, or failure to act on the part of,

the Committee, the Trustee, an Investment Manager or any other Fiduciary, except to the extent that liability cannot be waived.

8.12 Bonding. Every Fiduciary, unless exempted by ERISA, shall be bonded in an amount not less than ten percent of the amount of the fund such Fiduciary handles; provided, however, that the minimum bond shall be $1,000 and the maximum bond, $500,000. The amount of the bond shall be determined at the beginning of each Plan Year by the amount of funds handled by each such person, group, or class to be covered and their predecessors, if any, during the preceding Plan Year, or if there is no preceding Plan Year, then by the amount of the funds to be handled during the then current year. The bond shall provide protection to the Plan against any loss by reason of acts of fraud or dishonesty by the Fiduciary alone or in connivance with others. The surety shall be listed on the Department of Treasury's Listing of Approved Sureties, and the bond shall be in a form approved by the Secretary of Labor. Notwithstanding anything herein to the contrary, the cost of such bonds shall be an expense of the Plan and may, at the election of the Committee, be paid from the Plan assets or by the Employer.

8.13 Indemnification. The Employer shall indemnify each member of the Committee and each member of its Board from and against any and all liabilities, claims, costs and expenses incurred as a result of any act or omission in connection with the performance of fiduciary duties or responsibilities, if any, under the Plan and applicable law, except for liabilities, claims, costs and expenses arising from gross negligence or willful misconduct. It is specifically provided that the Employer may purchase out of its own funds, or the Trustee may purchase out of the Trust, insurance for the members of the Committee and any other Fiduciary appointed by the Board, the Employer or the Committee, and for the Trust itself, to cover liability or losses occurring by reason of the act or omission of any one or more of the members of the Committee or any other Fiduciary appointed to serve the Plan, provided such insurance permits recourse by the insurer against such Fiduciaries in the case of a breach of a fiduciary duty by one or more of the Fiduciaries.

8.14 Multiple Fiduciary Capacities. An individual, organization, firm or other entity may serve in more than one fiduciary capacity with respect to the Plan, including the ability to serve both as Trustee and as a member of the Committee.

8.15 Information to Members. The Committee shall make available to each Member and Beneficiary such records, documents and other data required by ERISA, and such Member or Beneficiary shall have the right to examine such materials at a reasonable time during normal business hours. Except as otherwise required by law, a Beneficiary's right to (and the Committee's duty to provide to the Beneficiary) information or data concerning the Plan does not arise until he first becomes entitled to receive a benefit under the Plan. Nothing included in the Plan, however, shall give a Member or Beneficiary the right to examine materials reflecting the compensation or benefits paid to any other individual Member or Beneficiary.

8.16 Reliance. Anyone required to give evidence under the terms of the Plan may do so by certificate, affidavit, document or other information that the person to act in reliance thereon may consider pertinent, reliable and genuine, and to have been signed, made or presented

by the proper party or parties. The Plan's Fiduciaries shall be fully protected in acting and relying upon any evidence described in this Section 8.16.

8.17 No Decisions by Interested Party in Own Benefit. A member of the Committee who is also a Member in the Plan shall not vote or act upon any matter relating solely to himself. In any case in which a member of the Committee is so disqualified to act, and the remaining members cannot agree, the Board shall appoint a temporary substitute member to exercise all of the powers of the disqualified member concerning the matter in which he is disqualified.

ARTICLE 9
MEMBER ADMINISTRATIVE PROVISIONS AND CLAIMS PROCEDURE

9.1 Beneficiary Designations. Each Member from time to time may designate any person or persons (who may be designated contingently or successively and may be an entity other than a natural person) as his Beneficiary or Beneficiaries to whom his Plan benefits are paid if he dies before receipt of all such benefits (if any are required to be paid at all). Each Beneficiary designation shall be on a form approved by the Committee and will be effective only when such form is filed with the Committee during the Member's lifetime.

Each Beneficiary designation filed with the Committee will cancel all Beneficiary designations previously filed with the Committee. In the event a married Member designates a Beneficiary other than his Spouse, such designation is subject to the provisions of Section 6.9.

9.2 No Beneficiary Designation. If a married Member fails to designate a Beneficiary or if a married Member names a Beneficiary other than his Spouse and the Spouse's consent is not on file with the Committee, the Member's Vested Accrued Benefit shall be paid to the designated Beneficiary only to the extent it is not required to be paid to his surviving Spouse (if any benefit is required to be paid at all).

If a Member fails to designate a Beneficiary in the manner provided under the Plan, and is not survived by a Spouse or if the Beneficiary designated by a deceased Member dies before him or before complete distribution of his benefits, the Committee shall direct the Trustee to distribute the balance of the Member's benefits to the Member's executor or administrator.

9.3 Personal Information to Committee. Each Member and each Beneficiary of a deceased Member must furnish to the Committee or Trustee, as designated by the Committee, such evidence, data or information as the Committee or Trustee considers necessary or desirable for purposes of administering the Plan. The provisions of the Plan are effective for the benefit of each Member upon the condition precedent that each Member will furnish promptly full, true and complete evidence, data and information when requested by the Committee or Trustee, provided that the Committee or Trustee shall advise each Member of the effect of his failure to comply with its request.

9.4 Address for Notification. Each Member and each Beneficiary of a deceased Member shall file with the Committee or Trustee, as designated by the Committee, from time to

time, in writing, his address and any change of address. Any communication, statement or notice addressed to a Member or Beneficiary at his last address filed with the Committee, or as shown on the records of the Employer, shall bind the Member or Beneficiary for all purposes under the Plan.

9.5 Location of Member or Beneficiary Unknown. In the event that all, or any portion, of the distribution payable to a Member or his Beneficiary hereunder shall, at the expiration of six months after it shall become payable, remain unpaid solely by reason of the inability of the Committee, after sending a registered letter, return receipt requested, to the last known address, and after further diligent effort, to ascertain the whereabouts of such Member or his Beneficiary, such amount shall be used in the same manner as a forfeiture under the Plan. In the event a Member or Beneficiary is located subsequent to his benefit being forfeited, such benefit shall be restored.

9.6 Notice of Change in Plan Terms. The Committee, within the time prescribed by ERISA, shall furnish all Members and Beneficiaries a summary plan description and a summary description of any material modification to the Plan, or notice of discontinuance of the Plan, and all other information required by ERISA to be furnished, without charge.

9.7 Review of Plan Documents and Information. Any Member or Beneficiary of a deceased Member may examine copies of the Plan, its summary descriptions, the latest annual report, any bargaining agreement, this document and the Trust Agreement, contract or any other instrument under which the Plan is established or maintained. The Chairman of the Committee will maintain all of the items listed in this Section 9.7 in his office, or in such other place or places as he may designate from time to time in order to comply with ERISA, for examination during reasonable business hours. Upon written request of a Member or a deceased Member's Beneficiary, the Committee shall furnish a copy of any item listed in this Section 9.7. The Committee may make a reasonable charge to the requesting party for copies so furnished.

9.8 Claims Procedure. Claims for benefits under the Plan may be filed with the Committee on forms supplied by the Employer. Written notice of the disposition of a claim shall be furnished to the claimant within 90 days after the claimant's application is filed (or within 180 days if the Committee has determined that special circumstances require an extension of time and has notified the claimant of the extension). In the event the claim is denied, (a) the reasons for the denial shall be specifically set forth in the notice in language calculated to be understood by the claimant, (b) pertinent Plan provisions shall be cited, (c) where appropriate, a description of any additional material or information necessary, and an explanation as to how the claimant can perfect the claim, shall be provided, and (d) the claimant shall be furnished an explanation of the Plan's claims review procedure and applicable time limits.

9.9 Claims Review Procedure. Any Employee, former Employee, or Beneficiary of either, who has been denied a benefit by a decision of the Committee pursuant to Section 9.8 shall be entitled to file with the Committee (on a form that may be obtained from the Committee) a request for a hearing. Such request, together with a written statement of the reasons that the claimant believes his claim should be allowed, shall be filed with the Committee no later than 60 days after receipt of the written notification provided for in Section 9.8.

The claimant or his representative shall have an opportunity to review all documents in the possession of the Committee that are pertinent to the claim at issue and its disallowance. The claimant or his representative shall have an opportunity to submit written comments, documents, records and other information in support of his claim. At any hearing that is conducted, either the claimant or the Committee may cause a court reporter to attend the hearing and record the proceedings. In such event, a complete written transcript of the proceedings shall be furnished to both parties by the court reporter. The full expense of any such court reporter and such transcript shall be borne by the party causing the court reporter to attend the hearing.

A final decision as to the allowance of the claim shall be made by the Committee within 60 days of receipt of the appeal (or within 120 days if the Committee has determined that special circumstances require an extension of time and has notified the claimant of the extension). The Committee's decision on appeal shall be communicated in writing to the claimant. Such communication shall be written in a manner calculated to be understood by the claimant and shall include specific reasons for the decision and specific references to the pertinent Plan provisions on which the decision is based.

ARTICLE 10
TOP HEAVY PLAN PROVISIONS

10.1 Purpose and Definitions. The purpose of this Article 10 is to ensure that Non-Key Employees receive the minimum benefits and Vesting required under Code Section 416 in the event that the Plan becomes a Top Heavy Plan for any Plan Year. For purposes of complying with the top heavy plan requirements under Code Section 416, the following definitions, in addition to certain definitions set forth in Article 2, shall apply.

(a) Top Heavy Plan. This Plan, if as of the Determination Date, the aggregate of the Present Value of Accrued Benefits for Key Employees under the Plan is greater than 60 percent of the aggregate Present Value of Accrued Benefits for all Employees under the Plan.

The Plan shall also be considered a Top Heavy Plan if it is part of a Required Aggregation Group that is a Top Heavy Group.

For purposes of calculating the 60 percent top heavy ratio described in this Section 10.1(a), the Accrued Benefits of Members who are not Key Employees but who were Key Employees in prior years, and Members who have not performed services for the Employer at any time during the one-year period ending on the applicable Determination Date, shall not be taken into account.

(b) Present Value of Accrued Benefits. The actuarially calculated present value of a Member's Accrued Benefit based on the following assumptions:

(1) Present values shall be determined as of the valuation date used for computing Plan costs for minimum funding purposes (regardless of whether a valuation is

actually performed for a particular year) that falls within the 12-month period ending on the Determination Date.

(2) Accrued Benefits shall be determined as if a Member voluntarily terminated service as of the valuation date.

(3) Present values shall be determined based on the interest and mortality rates used for minimum funding purposes.

(4) In the case of a Member other than a Key Employee, a Member's Present Value of Accrued Benefits shall be determined using the single accrual method used for all plans of the Employer, or if no such single method exists, using a method that results in benefits accruing not more rapidly than the slowest accrual rate permitted under Code Section 411(b)(1)(C).

(5) Notwithstanding the foregoing, the present value of the Employee's Accrued Benefit as of the Determination Date shall be increased by the distributions made with respect to the Employee under the Plan and any Plan aggregated with the Plan under Code Section 416(g)(2) during the one-year period ending on the Determination Date. The preceding sentence shall also apply to distributions under a terminated plan that, had it not been terminated, would have been aggregated with the Plan under Code Section 416(g)(2)(A)(i). In the case of a distribution made for a reason other than severance from employment, death or disability, this provision shall be applied by substituting "five-year period" for "one-year period."

(c) Top Heavy Group. Any aggregation group if, as of the Determination Date, the sum of the aggregate accounts of Key Employees under all defined contribution plans included in such group and the Present Value of Accrued Benefits for all Key Employees under all defined benefit plans in such group, exceeds 60 percent of a similar sum determined for all Employees.

(d) Permissive Aggregation Group. The Required Aggregation Group plus any other plan or plans of the Employer that, when considered as a group with the Required Aggregation Group, would continue to satisfy the requirements of Code Sections 401(a)(4) and 410. If the Permissive Aggregation Group is not a Top Heavy Group, then no plans in such group shall be considered Top Heavy.

(e) Required Aggregation Group. In determining a Required Aggregation Group hereunder, each qualified plan of the Employer in which a Key Employee is a participant in the Plan Year including the Determination Date and each other plan of the Employer that enables any plan in which a Key Employee participates to meet the requirements of Code Section 401(a)(4) or 410 will be required to be aggregated. In the case of a Required Aggregation Group, each plan in the group will be considered a Top Heavy Plan if the Required Aggregation Group is a Top Heavy Group. No plan in the Required Aggregation Group will be considered a Top Heavy Plan if the Required Aggregation Group is not a Top Heavy Group.

(f) Minimum Normal Retirement Benefit. The Minimum Normal Retirement Benefit equals the applicable percentage of the Non-Key Employee's Average Annual Compensation, where applicable percentage is two percent multiplied by the number of years of Benefit Accrual Service (not to exceed ten) earned as a Non-Key Employee Member in years in which this Plan is a Top Heavy Plan.

10.2 Minimum Normal Retirement Benefit Requirement. If the Plan is a Top Heavy Plan, the Plan guarantees a Minimum Normal Retirement Benefit for each Non-Key Employee who is a Member in the Plan.

The Plan shall be deemed to satisfy the Minimum Normal Retirement Benefit requirement for a Non-Key Employee if the Non-Key Employee's Accrued Benefit at the end of any year in which the Plan is a Top Heavy Plan is at least equal to the Minimum Normal Retirement Benefit. For purposes of determining whether the Minimum Normal Retirement Benefit requirement is satisfied (whether through the actual Accrued Benefit or under this Section 10.2 and Section 10.3), a Member's normal retirement benefit shall be tested using a single life only annuity (with no ancillary benefits) commencing at age 65. If the normal retirement benefit is tested in any other form, it shall be actuarially adjusted, using the Actuarial Equivalent definition under Section 2.2 in accordance with Regulation Section 1.416-1, M-3.

The Minimum Normal Retirement Benefit shall not be integrated with Social Security and contributions to Social Security shall not be taken into account for purposes of determining whether the Minimum Normal Retirement Benefit has been provided.

10.3 Additional Accruals. If, at the end of any year in which the Plan is a Top Heavy Plan, a Non-Key Employee Member's Accrued Benefit is not at least equal to his Minimum Normal Retirement Benefit, then the Non-Key Employee Member shall earn the additional accrual necessary to increase his Accrued Benefit to the Minimum Normal Retirement Benefit. The Non-Key Employee Member's Accrued Benefit shall never be less than his Minimum Normal Retirement Benefit regardless of the Plan's Top Heavy status in Plan Years subsequent to a Plan Year in which he earned an additional accrual under Section 10.2 and this Section 10.3.

10.4 Minimum Vesting Requirement. If the Plan is considered a Top Heavy Plan, then the following Vesting schedule shall come into effect and replace the Vesting schedules in Section 5.1.

Years of Vesting Service	Percent Vested
Less than three	0%
Three or more	100%

The implementation of the above Vesting schedule shall be automatic and shall be deemed to have been made by a Plan amendment as of the Determination Date immediately preceding the first day of the Plan Year in which the Plan is a Top Heavy Plan, and shall be subject to the provisions of Section 5.2 (relating to a change of Vesting schedules), but shall not

be applicable to Members who do not complete at least one Hour of Service after the Plan becomes a Top Heavy Plan.

If on a subsequent Determination Date the Plan is no longer a Top Heavy Plan, the Plan may be amended to return to the prior Vesting schedules under Section 5.1. Such Plan amendment shall be subject to the provisions of Section 5.2, but in no way shall the amendment decrease the Vested percentage of a Member's Accrued Benefit that became subject to the top heavy Vesting schedule set forth in the above table under this Section 10.4.

ARTICLE 11
AMENDMENT, TERMINATION, MERGER AND MISCELLANEOUS PLAN PROVISIONS

11.1 Intent to Qualify. This Plan is intended to be a qualified defined benefit pension plan within the meaning of Code Section 401(a). The Trust is intended to be an exempt trust within the meaning of Code Section 501(a).

11.2 Exclusive Benefit/Prohibition on Diversion of Assets. This Plan has been executed for the exclusive benefit of the Members and their Beneficiaries. All assets of the Plan shall be held in the Trust for the exclusive benefit of the Members and their Beneficiaries hereunder. So far as possible, the Plan shall be interpreted and administered in a manner consistent with this intent and with the intention of the Employer that the Plan shall at all times comply fully with the requirements of applicable laws and legal guidance. Neither the Employer nor the Committee shall exercise any power or right, or perform any act, that is in conflict with or violates such laws or legal guidance. Any power or right granted under the Plan, or retained by the Employer, shall be void to the extent that its exercise or retention shall violate laws or legal guidance. The Employer shall make any and all retroactive amendments to the Plan that are required under applicable laws and legal guidance, in order to establish and maintain the Plan as a qualified plan pursuant to Code Section 401(a) and the Trust, which is part of the Plan, as tax exempt pursuant to Code Section 501(a). Except as provided in Section 4.5 or 12.2, or otherwise specifically permitted by law, it shall be impossible by operation of the Plan or Trust, by termination of either, by power of revocation or amendment, by the happening of any contingency, by collateral arrangement or by any other means, for any part of the corpus or income of the Trust or any funds contributed to the Trust to be used for, or diverted to, purposes other than the exclusive benefit of Members and their Beneficiaries.

11.3 Nondiscrimination. All provisions of the Plan shall be interpreted and applied in a uniform and nondiscriminatory manner.

11.4 Nonalienation of Benefits. Subject to the exceptions set forth below in this Section 11.4, no benefit payable from the Trust to any person (including a Member or his Beneficiary) shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber or charge same shall be void. No such benefit shall be liable in any manner for, or subject to, the debts, contracts, liabilities, engagements or torts of any such person, nor shall it be subject to attachment or legal process for or against such person, and the same shall not be recognized by the Trustee, except to the extent required by law.

The preceding paragraph shall not apply to the extent that a Member or Beneficiary is indebted to the Plan for any reason under a provision of the Plan. At the time a distribution is to be made to or for the benefit of a Member or Beneficiary, such portion of the distribution amount equal to the indebtedness shall be paid by the Trustee to the Trustee or the Committee, at the direction of the Committee, to apply against or discharge the indebtedness. Prior to making a payment, however, the Committee must give the Member or Beneficiary written notice that the indebtedness is to be so paid in whole or part from his vested Accrued Benefit. If the Member or Beneficiary does not agree that the indebtedness is a valid claim against his vested Accrued Benefit, he shall be entitled to a review of the validity of the claim in accordance with Sections 9.8 and 9.9.

The first paragraph of this Section 11.4 shall not apply to a QDRO or such other domestic relations order permitted to be so treated by the Committee under the provisions of the Retirement Equity Act of 1984. All rights and benefits, including elections provided to Members, their Spouses or Beneficiaries, shall be subject to the rights accorded Alternate Payees under QDROs. To the extent provided under a QDRO, a former Spouse of a Member shall be treated as his Spouse or surviving Spouse for purposes of the Plan.

11.5 Applicable Law. The Plan shall be construed and administered in accordance with ERISA and the laws of the State of Texas, to the extent that such laws are not preempted by ERISA.

11.6 Headings Not to Control. Titles, headings and subheadings have been used in the Plan for convenience of reference only and are to be ignored in the interpretation of the Plan's provisions.

11.7 Gender and Number. Words used herein in the masculine or feminine gender shall be construed as the feminine or masculine gender, respectively, where appropriate. Words used in the singular or plural shall be construed as the plural or singular, respectively, where appropriate.

11.8 Severability. Should any provision of the Plan be determined to be void by a court of competent jurisdiction, the Plan will continue to operate, subject to the Board's right to amend or terminate under Sections 11.14 and 11.16, and for purposes of the jurisdiction of the court only, will be deemed not to include the provision determined to be void.

11.9 No Contract of Employment. The adoption and maintenance of the Plan shall not be deemed to constitute a contract between the Employer and any Employee or Member, and shall not be considered an inducement to the employment of any person. Nothing included herein shall be construed to give any Employee or Member the right to be retained in the employ of the Employer, or to interfere with the right of the Employer to terminate the employment of any Employee or Member at any time.

11.10 No Duplication of Benefits. There shall be no duplication of benefits under the Plan as a result of employment by more than one Employer.

11.11 Legal Action. In the event a claim, suit or proceeding is brought regarding the Plan and/or the Trust, to which the Committee and/or the Trustee may be a party, and such claim, suit or proceeding is resolved in favor of the Committee and/or the Trustee, they shall be entitled to reimbursement from the Trust for their costs, attorneys' fees and other expenses for which they may be liable.

Except as otherwise provided by ERISA, only the Employer, the Committee and the Trustee shall be necessary parties to any court proceeding involving the Trustee or the Trust. No Member or Beneficiary shall be entitled to any notice of process unless required by ERISA. Any final judgment entered in any proceeding shall be binding and conclusive upon the Employer, the Committee, the Trustee, the Members and their Beneficiaries.

11.12 Protective Clause. Neither the Sponsor, the Employer, the Committee nor the Trustee, nor their successors, shall be responsible for the validity of an insurance contract issued hereunder, or for the failure on the part of an insurer to make payments provided under any such contract, or for the action of any person that may delay payment or render a contract null, void or unenforceable, in whole or in part.

11.13 Action by Sponsor or Employer. Whenever the Sponsor or Employer is permitted or required, under the terms of the Plan, to perform any act, such act shall be performed by a person duly authorized by its legally constituted authority.

11.14 Right to Amend and Terminate. The Employer hopes and expects to continue the Plan indefinitely, but continuation of the Plan is not assumed as a contractual obligation. Therefore, the Employer reserves the right to amend the Plan in whole or in part at any time and from time to time, without the consent of any other party, except that at no time shall an amendment

(a) violate the exclusive benefit requirement or the prohibition on diversion of assets under Section 11.2;

(b) affect the duties, rights or responsibilities of the Trustee or the Committee without the written consent of the affected party; or

(c) reduce the Accrued Benefit of a Member, except to the extent permitted by applicable law, regulation or ruling that specifically permits the reduction of same. Any amendment shall be treated as prohibitively reducing a Member's Accrued Benefit determined immediately before the adoption of such amendment if it has the effect, with respect to benefits accrued prior to adoption of the amendment, of (1) eliminating or reducing an early retirement benefit or a retirement type subsidy, or (2) eliminating an optional form of benefit.

Each amendment shall be in writing and shall state the date on which it is effective (which may be a retroactive or a prospective effective date). Amendments shall be approved by the Board or by the Committee, if so authorized by the Board.

No amendment that affects the rights, duties or responsibilities of the Trustee, Committee or an Investment Manager may be made without such party's written consent. The Trustee shall not be required to execute any such amendment unless the Trust Agreement is amended thereby.

Upon termination of the Plan, a Member's benefit shall be determined using the interest rate and mortality table otherwise applicable for determining the Member's benefit under the Plan without regard to the termination of the Plan. Any interest rate used to determine a Cash Balance Member's benefit under the Plan that is a variable rate, including any interest crediting rate and any interest rate used to determine annuity benefits, shall be determined as the average of the rates of interest used under the Plan for that purpose during the five-year period ending on the Plan termination date.

11.15 Security Required for Certain Amendments. For Plan Years beginning prior to January 1, 2008, in accordance with ERISA Section 307, any amendment adopted by the Employer that has the effect of increasing the Plan's current liability (as such term is defined in ERISA Section 302(d)) such that the funded current liability percentage (as also defined in ERISA Section 302(d)) for the Plan Year in which such amendment takes effect is less than 60 percent, including the amount of the unfunded current liability (as defined in ERISA Section 302(d)) under the Plan attributable to the Plan amendment, then the Sponsor (or any member of the controlled group of the Sponsor) shall be required prior to such amendment taking effect to provide security to the Plan.

The security required under this Section 11.15 shall consist of

(a) a bond issued by a corporate surety company that is an acceptable surety for purposes of ERISA Section 412,

(b) cash, or United States obligations that mature in three years or less, held in escrow by a bank or similar financial institution, or

(c) such other form of security as is satisfactory to the Secretary of the Treasury and the parties involved.

The amount of the security shall be equal to the excess of (d) over (e), where

(d) equals the lesser of

(1) the amount of additional Plan assets that would be necessary to increase the funded current liability percentage under the Plan to 60 percent, including the amount of the unfunded current liability under the Plan attributable to the Plan amendment, or

(2) the amount of the increase in current liability under the Plan attributable to the Plan amendment, and

(e) equals $10,000,000.

The security shall be released (and any amounts thereunder shall be refunded together with any interest accrued thereon) at the end of the first Plan Year that ends after the provision of the security and for which the funded current liability percentage is not less than 60 percent. If the IRS publishes regulations prescribing the partial release of security by reason of increases in the funded current liability percentage, the security shall be released under the Plan in accordance with such regulations.

11.16 Termination of Plan. The Employer shall have the right, at any time, to suspend or discontinue its contributions under the Plan, and to terminate the Plan and Trust at any time. The Plan shall terminate upon the first to occur of the following:

(a) the date terminated by action of the Employer;

(b) the date the Employer is judicially declared bankrupt or insolvent; or

(c) the dissolution, merger, consolidation or reorganization of the Employer or the sale by the Employer of all or substantially all of its assets, unless the successor or purchaser makes provision to continue the Plan, in which event the successor or purchaser shall become the Employer under the Plan.

Upon termination of the Plan, the distribution provisions of the Plan shall remain operative.

To liquidate the Trust, the Committee shall purchase either deferred or immediate annuity contracts (as the circumstances require and depending on the payment status of benefits) for each Member whose lump sum Actuarial Equivalent Vested Accrued Benefit exceeds $3,500 ($5,000 for Plan Years beginning after December 31, 1997) and who does not elect immediate distribution. Any such annuity contracts must protect a Member's distribution rights under the Plan.

The Trust shall continue until the Trustee has distributed all of the benefits under the Plan in accordance with the direction of the Committee. A resolution or amendment to freeze all future benefit accruals, but otherwise to continue to maintain the Plan, shall not be a termination for purposes of this Section 11.16. Further, a merger or direct transfer described in Section 11.18 is not a termination for purposes of the special distribution provisions described in this Section 11.16.

In the event of Plan termination, the benefit of any Highly Compensated Employee or any highly compensated former employee shall be limited to a benefit that is nondiscriminatory under Code Section 401(a)(4).

11.17 Vesting upon Termination. Notwithstanding any other provision of the Plan to the contrary, upon the full or partial termination of the Plan, an affected Member's right to his Accrued Benefit shall be 100 percent Vested to the extent funded.

11.18 Mergers, Consolidations and Transfers. In the event of a merger or consolidation of the Plan with, or transfer, in whole or in part, of the assets and liabilities of the Trust to another trust held under another plan of deferred compensation maintained or to be established for the benefit of some or all of the Members, the assets of the Trust with respect to such Members shall be transferred to the other trust only if

(a) each Member would (if either this Plan or the other plan then terminated) receive a benefit immediately after the merger, consolidation or transfer that is equal to or greater than the benefit he would have been entitled to receive immediately before the merger, consolidation or transfer;

(b) actions of the Sponsor, or of any new or successor sponsor for the affected Members, authorize such transfer of assets, and in the case of the new or successor sponsor, its resolutions include an assumption of liabilities with respect to such Members' inclusion in the new sponsor's plan; and

(c) such other plan and trust satisfy the requirements of Code Sections 401(a) and 501(a).

11.19 Named Fiduciaries. The Named Fiduciaries of this Plan are (a) the Sponsor, (b) the Employer, (c) the Committee, (d) the Trustee and (e) any Investment Manager appointed under Section 8.2(b). The Named Fiduciaries shall have only those specific powers, duties, responsibilities and obligations as are specifically given them under the Plan. In general, the Sponsor shall have sole authority to appoint and remove the Trustee and the Committee, and to amend or terminate the Plan, in whole or in part. The Employer shall have sole responsibility for making contributions for Members who are its Employees, as provided under Article 4. The Committee shall have sole responsibility for the administration of the Plan, which responsibility is specifically described in the Plan. The Trustee shall have sole responsibility for management of the Trust assets, except those assets the management of which has been assigned to an Investment Manager, who shall be solely responsible for the management of the assets assigned to it, all as specifically provided herein. Each Named Fiduciary warrants that any direction given, information furnished or action taken by it is in accordance with the Plan's provisions, authorizing or providing for such direction, information or action. Furthermore, each Named Fiduciary may rely upon any direction, information or action of another Named Fiduciary as being proper under the Plan, and is not required to inquire into the propriety of any such direction, information or action. It is intended that each Named Fiduciary shall be responsible for the proper exercise of its own powers, duties, responsibilities and obligations under the Plan. Any person or group may serve in more than one fiduciary capacity.

11.20 Successors. In the event of the dissolution, merger, consolidation or reorganization of the Sponsor or an Employer, provision may be made by which the Plan will be continued by the successor to the Sponsor or the Employer. In this case, the successor shall be substituted for the Sponsor or the Employer, as the case may be, under the Plan. The substitution of the successor shall constitute an assumption of Plan liabilities by the successor, and the successor shall have all of the powers, duties and responsibilities of the Sponsor or the Employer under the Plan.

11.21 Fiduciaries Not Insurers. The Fiduciaries under the Plan in no way guarantee the Trust from investment loss or depreciation. The Employer does not guarantee the payment of any benefit that may be or become due to any person from the Trust. The liability of the Committee and the Trustee to make any payment from the Trust at any time is limited to the then available Trust assets.

11.22 Notice and Waiver of Notice. Whenever written notice concerning a matter under the Plan is required to be given hereunder, it shall be deemed given on the date deposited at a United States Postal Service station, first class postage paid. Notice may be waived by any party otherwise entitled thereto.

11.23 Returned Payments. If no one claims a payment or distribution made from the Trust, or if a payment that was mailed to the last known address of a Member or Beneficiary is returned because the addressee failed to claim the payment, the Trustee shall promptly cease benefit payments, redeposit into the Trust such payment or payments that remain unclaimed and notify the Committee. The Committee and/or the Trustee shall conduct a reasonable search for the Member or Beneficiary, but if after a reasonable search there is no success, the provisions of Section 9.5 shall apply to the benefit payments.

11.24 Release of Claims. Any payment to a Member, his legal representative, Beneficiary, or to any guardian or committee appointed for such Member or Beneficiary shall, to the extent thereof, be in full satisfaction of all claims hereunder against the Sponsor, Employer, Committee, Plan and Trustee, any of whom may require such Member, legal representative, Beneficiary, guardian or committee, as a condition precedent to such payment, to execute a receipt and release thereof in such form as shall be determined by the Sponsor, Employer, Committee, Plan or Trustee

11.25 Payments to Minors or Incompetents. In the event a distribution is to be made to a minor Beneficiary, or to the custodian for the minor Beneficiary under the Uniform Gift to Minors Act or Gift to Minors Act, if permitted by the laws of the state in which the Beneficiary resides, the distribution to the legal guardian, custodian or parent of the minor Beneficiary shall fully discharge the Sponsor, Employer, Committee, Plan and Trustee from further liability on account thereof.

If the Committee receives satisfactory evidence (a) that any person entitled to a benefit under the Plan is physically, mentally or legally incompetent to receive the benefit and give a valid receipt for the benefit at the time it is payable, and (b) that an individual or institution is then maintaining or has custody of the person and/or that a guardian or other representative of the person has been appointed to see to his affairs, the Committee may direct the Trustee to pay the benefit to the individual or institution maintaining or then having custody of the person and/or the guardian or other representative of the person, and the receipt by that individual, institution, guardian or other representative shall fully discharge the Sponsor, Employer, Committee, Plan and Trustee from further liability to such person.

11.26 Multiple Copies of Plan and/or Trust Documents. This Plan and the Trust Agreement may be executed in any number of counterparts, each of which shall be deemed an original but all of which shall constitute one and the same Plan or Trust Agreement (as the case may be), and shall be binding on the respective successors and assigns of the Employer and other Fiduciaries.

ARTICLE 12
RESTRICTIONS ON CERTAIN BENEFIT PAYMENTS

12.1 Application of Assets on Termination or Discontinuance. If the Plan is terminated by the Employer, the Trustee shall liquidate all assets of the Plan and shall determine the value of the Trust as of the business day next following the date of such termination. Subject to the provisions of Sections 12.2 through 12.10, the Committee shall allocate assets of the Plan among Members and Beneficiaries according to the following priorities:

(a) to defray all costs and charges (including those of counsel, the Trustee and any other persons engaged by the Committee or Trustee, with the Committee's approval, providing services to the Plan) for the orderly liquidation and distribution of the Trust as provided in this Section 12.1;

(b) to a Member's benefits payable from his Employee contributions (if any);

(c) to benefits payable as an annuity:

(1) in the case of a benefit of a Member or Beneficiary that was in pay status as of the beginning of the three-year period ending on the Plan's termination date, each such benefit, based on the Plan's provisions (as in effect during the five-year period ending on such date) under which such benefit would be the least; or

(2) in the case of a Member's or Beneficiary's benefit (other than a benefit described in Section 12.1(c)(1)) that would have been in pay status as of the beginning of such three-year period if the Member had retired prior to the beginning of the three-year period and if his benefits had commenced (in the normal form of annuity under the Plan) as of the beginning of such period, each such benefit based on the provisions of the Plan (as in effect during the five-year period ending on such date) under which such benefit would be the least.

For purposes of Section 12.1(c)(1), the lowest benefit in pay status during a three-year period is the benefit in pay status for such period.

(d) all other Plan benefits insured by the PBGC;

(e) all other Vested benefits under the Plan; and

(f) any other benefits under the Plan (but not any benefits to which a Member does not have a Vested right thereto or which a Member has not yet satisfied the requirements therefor).

If assets are insufficient to provide all benefits under the Plan, the Committee shall cause the Plan assets to be allocated to satisfy obligations within each category by order of priority. If assets are insufficient to provide all benefits under a priority category, the Plan assets shall be allocated to Members within that category in the ratio that each Member's total benefits bears to the total benefits of all Members within that category. The Committee shall cause the assets that are not required to be allocated under ERISA Sections 4044(a)(1), (2), (3) and (4)(A) to be allocated in a manner that shall reduce to the extent possible discrimination as described in Code Section 401(a)(4).

In the event that funds are insufficient, Members shall have no recourse against the Sponsor, the Employer, the Committee, the Trust, the Trustee or any other Fiduciary, Employee or organization providing services to the Plan.

12.2 Surplus After Termination. If the Employer has overfunded the Plan as of the time the Plan is terminated, the Trustee may return the amount by which the Employer has overfunded the Plan to the Employer. The Employer shall state by written request to the Trustee the amount of the overfunding it wishes the Trustee to return after satisfying all liabilities under the terminated Plan.

12.3 Recapture of Certain Payments. If the Plan is terminated as to the Employer, there shall be repaid to the Trust the following amount in respect of any benefit whose payment commenced within the three-year period immediately preceding the date of termination;

(a) the payments received by a Member in respect of benefits during the three-year period minus

(b) the sum of

(1) the total of the benefits that would have been received by a Member in the three-year period if payments were made in the form of a life annuity,

(2) total of the excesses for each of the three years of $10,000 (or the actual payment of such benefits in the year, if less) over the amount in Section 12.3(b)(1) applicable to the year, and

(3) the present value at the date of Plan termination of the portion of the benefits guaranteed by the PBGC as if the benefits commenced as a life annuity.

Repayment under this Section 12.3 shall only be required to provide a full allocation in respect of all benefits in Sections 12.1(a) and (b) and shall not be required in respect of any amount whose repayment would, in the determination of the PBGC, cause substantial economic hardship to a Member or his Beneficiary.

12.4 Benefit Restrictions for Certain Employees Before 1992. Notwithstanding any other provision of the Plan to the contrary, the Employer contributions that the Trustee may use

to provide benefits for Members who are among the 25 highest paid Employees (the "Original 25 Employees") as of the Effective Date (including any Employees who are not Members on the Effective Date but who later may become Members) and whose annual retirement benefits shall exceed $1,500 shall not exceed the greatest of

(a) $20,000,

(b) an amount equal to 20 percent of the first $50,000 of the Member's Average Annual Compensation multiplied by the number of years elapsed between the Effective Date and the earliest to occur of:

(1) the date the Plan terminates,

(2) the date the Member's retirement benefit becomes payable, or

(3) the date the Employer fails to meet the full current costs of the Plan, or

(c) if an Employee is a substantial owner (as defined in ERISA Section 4022(b)(5)), the present value of his guaranteed benefit under ERISA Section 4022, or the present value of the benefit he would be guaranteed under ERISA Section 4022 if the Plan terminated on the date benefits commence (determined in accordance with PBGC regulations). If an Employee is not a substantial owner, the present value of his maximum benefit under ERISA Section 4022(b)(3)(B) on the earlier of the date the Plan terminated or the date his benefits commence (determined in accordance with PBGC regulations) regardless of any other limitations in ERISA Section 4022.

12.5 Substantial Changes in Plan. If the Employer changes the Plan so as to increase substantially the extent of possible discrimination as to contributions and as to benefits actually payable in the event of the subsequent termination of the Plan or the subsequent discontinuance of contributions under the Plan, the Employer shall apply the provisions of Section 12.4 to the 25 highest paid Employees (the "New 25 Employees") as of the date of the change (including any Employees who later may become Members) and whose annual retirement benefit shall exceed $1,500.

The Committee shall continue the restrictions described in Section 12.4 to the Original 25 Employees for the period the restrictions apply to them despite imposing restrictions on the New 25 Employees.

The Committee shall apply the restrictions in Section 12.4 to the New 25 Employees as if the Effective Date is the date of the change described in the first paragraph of this Section 12.5. Further, the Committee shall apply the restrictions of Section 12.4 to the New 25 Employees substituting for Section 12.4(b) the greater of the following:

(a) the Employer contributions (or the funds attributable to Employer contributions) the Trustee would have applied to provide a Member's retirement benefit if the Employer had not changed the Plan, or

(b) the sum of

(1) the Employer contributions (or the funds attributable to Employer contributions) the Trustee would have applied to provide a Member's retirement benefit if the Employer had terminated the Plan the day before the date of the change, and

(2) the product of the number of years the Employer satisfied the full current costs of the Plan after the date of the change multiplied by the smaller of $10,000 or 20 percent of a Member's annual Compensation.

12.6 Termination of Certain Members. If a Member to whom the limitations of Section 12.4 or 12.5 apply terminates employment while the limitations are in effect, the Member may nevertheless receive a lump sum payment of benefits in excess of such limitations provided the Member enters into an agreement with the Trustee requiring the Member to repay to the Trustee all amounts he has received in excess of such limitations. The Member's requirement to repay shall apply in the event the Plan terminates within the restricted ten-year period or if within such period the Employer has not met the Plan's full current costs. The Trustee shall not pay any benefit to a Member under this Section 12.6 unless the Member provides adequate security for his contingent repayment obligation. Such security shall be in the form required by regulations or promulgations of the IRS.

12.7 Full Payment While Plan in Effect. The restrictions in Section 12.4 shall not prevent the current payment of full retirement benefits called for by the Plan for any retired Member while the Plan is in full effect and the Employer has met its full current costs.

12.8 Restrictions Not to Apply to Death Benefits. The restrictions in Section 12.4 shall not prevent the full payment of any insurance, death or survivor's benefits on behalf of a Member who dies while the Plan is in full effect and the Employer has met its full current costs.

12.9 Lapse on Restrictions. The Section 12.4 restrictions shall only apply if

(a) the Employer terminates the Plan within ten years of the Effective Date, or

(b) one of the Original 25 Employees' retirement benefits becomes payable within ten years of the Effective Date.

If one of the Original 25 Employees' benefits is subject to restriction under Section 12.4 because of Section 12.9(b), then the Trustee shall apply the restrictions only until the date that is ten years from the Effective Date.

12.10 Benefit Restrictions for Certain Employees.

(a) For Plan Years beginning on or after January 1, 1992 and before January 1, 2008, benefits distributed to any of the 25 most Highly Compensated Employee and highly compensated former employees with the greatest compensation in the current or prior year are restricted such that the monthly payments are no greater than an amount equal to the monthly payment that would be made on behalf of such individual under a straight life annuity that is the actuarial equivalent of the sum of the individual's Accrued Benefit, the individual's other benefits under the Plan (other than a Social Security supplement within the meaning of Regulation Section 1.411(a)-7(c)(4)(ii)), and the amount the individual is entitled to receive under a Social Security supplement. However, the limitation of this Section 12.10 shall not apply if

(1) after payment of the benefit to an individual described above, the value of Plan assets equals or exceeds 110 percent of the value of current liabilities, as defined in Code Section 412(1)(7);

(2) the value of the benefits for an individual described above is less than one percent of the value of current liabilities before distribution; or

(3) the value of the benefits payable under the Plan to an individual described above does not exceed $5,000 ($3,500 for Plan Years beginning prior to August 5, 1997).

(b) For purposes of this Section 12.10, benefit includes any periodic income, any withdrawal values payable to a living Member, and any death benefits not provided for by insurance on the individual's life.

(c) An individual's otherwise restricted benefit may be distributed in full to the affected individual if, prior to receipt of the restricted amount, the individual enters into a written agreement with the Committee to secure repayment to the Plan of the restricted amount. The restricted amount is the excess of the amounts distributed to the individual (accumulated with reasonable interest) over the amounts that could have been distributed to the individual under the straight life annuity described above (accumulated with reasonable interest). The individual may secure repayment of the restricted amount upon distribution by

(1) entering into an agreement for promptly depositing in escrow with an acceptable depositary, property having a fair market value equal to at least 125 percent of the restricted amount;

(2) providing a bank letter of credit in an amount equal to at least 100 percent of the restricted amount; or

(3) posting a bond equal to at least 100 percent of the restricted amount. The bond must be furnished by an insurance company, bonding company or other surety for federal bonds.

(d) The escrow arrangement may permit an individual to withdraw from escrow amounts in excess of 125 percent of the restricted amount. If the market value of the property in an escrow account falls below 110 percent of the remaining restricted amount, the individual must deposit additional property to bring the value of the property held by the depositary up to 125 percent of the restricted amount. The escrow arrangement may provide that the individual has the right to receive any income from the property placed in escrow, subject to the individual's obligation to deposit additional property, as set forth in the preceding sentence.

(e) A surety or bank may release any liability on a bond or letter of credit in excess of 100 percent of the restricted amount.

(f) If the Committee certifies to the depositary, surety or bank that the individual (or the individual's estate) is no longer obligated to repay any restricted amount, a depositary may deliver to the individual any property held under an escrow arrangement, and a surety or bank may release any liability on an individual's bond or letter of credit.

(g) Notwithstanding the foregoing, with respect to Plan Years beginning prior to January 1, 1992, compliance with the Plan and Treasury Regulations then in effect shall be deemed compliance with this Section 12.10.

12.11 No Decrease in Benefits by Change in Social Security. In the case of a Member or Beneficiary who is receiving benefits under the Plan or a Member who has terminated employment with the Employer and has a nonforfeitable Accrued Benefit under the Plan, any increase in the taxable wage base or the benefit level payable under Title 11 of the federal Social Security Act shall not affect in any way the benefits payable under the Plan to the Member or Beneficiary. The Plan does not permit the recalculation of any benefits accrued before the Member's termination of employment on the basis of change in Social Security benefit levels or the taxable wage base in effect during years of Benefit Accrual Service after re-employment with the Employer.

ARTICLE 13
LIMITATIONS APPLICABLE IF THE PLAN'S AFTAP IS LESS THAN 80 PERCENT OR IF THE SPONSOR IS IN BANKRUPTCY

13.1 Limitations Applicable if the Plan's AFTAP is Less than 80 Percent, But Not Less than 60 Percent. Notwithstanding any other provisions of the Plan, if the Plan's AFTAP for a Plan Year is less than 80 percent (or would be less than 80 percent to the extent described in Section 13.1(b) below) but is not less than 60 percent, then the limitations set forth in this Section 13.1 shall apply.

(a) 50 Percent Limitation on Single Sum Payments, Other Accelerated Forms of Distribution, and Other Prohibited Payments. A Member or Beneficiary is not permitted to elect, and the Plan shall not pay, a single sum payment or other optional form of benefit that includes a prohibited payment with an annuity starting date on or after the applicable section 436 measurement date, and the Plan shall not make any payment for the purchase of an irrevocable commitment from an insurer to pay benefits or any other payment or transfer that is a prohibited

payment, unless the present value of the portion of the benefit that is being paid in a prohibited payment does not exceed the lesser of:

(1) 50 percent of the present value of the benefit payable in the optional form of benefit that includes the prohibited payment; or

(2) 100 percent of the PBGC maximum benefit guarantee amount (as defined in Regulation Section 1.436-1(d)(3)(iii)(C)).

The limitation set forth in this Section 13.1(a) does not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Member. If an optional form of benefit that is otherwise available under the terms of the Plan is not available to a Member or Beneficiary as of the annuity starting date because of the application of the requirements of this Section 13.1(a), the Member or Beneficiary is permitted to elect to bifurcate the benefit into unrestricted and restricted portions (as described in Regulation Section 1.436-1(d)(3)(iii)(D)). The Member or Beneficiary may also elect any other optional form of benefit otherwise available under the Plan at that annuity starting date that would satisfy the 50 percent/PBGC maximum benefit guarantee amount limitation described in this Section 13.1(a), or may elect to defer the benefit in accordance with any general right to defer commencement of benefits under the Plan.

(b) Plan Amendments Increasing Liability for Benefits. No amendment to the Plan that has the effect of increasing liabilities of the Plan by reason of increases in benefits, establishment of new benefits, changing the rate of benefit accrual, or changing the rate at which benefits become nonforfeitable shall take effect in a Plan Year if the AFTAP for the Plan Year is

(1) less than 80 percent; or

(2) 80 percent or more, but would be less than 80 percent if the benefits attributable to the amendment were taken into account in determining the AFTAP.

The limitation set forth in this Section 13.1(b) does not apply to any amendment to the Plan that provides a benefit increase under a plan formula that is not based on compensation, provided that the rate of such increase does not exceed the contemporaneous rate of increase in the average wages of Members covered by the amendment.

13.2 Limitations Applicable if the Plan's AFTAP is Less than 60 Percent. Notwithstanding any other provisions of the Plan, if the Plan's AFTAP for a Plan Year is less than 60 percent (or would be less than 60 percent to the extent described in Section 13.2(b)), then the limitations in this Section 13.2 apply.

(a) Single Sums, Other Accelerated Forms of Distribution, and Other Prohibited Payments Not Permitted. A Member or Beneficiary is not permitted to elect, and the Plan shall not pay, a single sum payment or other optional form of benefit that includes a prohibited payment with an annuity starting date on or after the applicable section 436 measurement date, and the Plan shall not make any payment for the purchase of an irrevocable

commitment from an insurer to pay benefits or any other payment or transfer that is a prohibited payment. The limitation set forth in this Section 13.2(a) does not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Member.

(b) Shutdown Benefits and Other Unpredictable Contingent Event Benefits Not Permitted to be Paid. An unpredictable contingent event benefit with respect to an unpredictable contingent event occurring during a Plan Year shall not be paid if the AFTAP for the Plan Year is

(1) less than 60 percent; or

(2) 60 percent or more, but would be less than 60 percent if the AFTAP were redetermined applying an actuarial assumption that the likelihood of occurrence of the unpredictable contingent event during the Plan Year is 100 percent.

(c) Benefit Accruals Frozen. Benefit accruals under the Plan shall cease as of the applicable section 436 measurement date. In addition, if the Plan is required to cease benefit accruals under this Section 13.2(c), then the Plan is not permitted to be amended in a manner that would increase the liabilities of the Plan by reason of an increase in benefits or establishment of new benefits.

13.3 Limitations Applicable if the Sponsor is in Bankruptcy. Notwithstanding any other provisions of the Plan, a Member or Beneficiary is not permitted to elect, and the Plan shall not pay, a single sum payment or other optional form of benefit that includes a prohibited payment with an annuity starting date that occurs during any period in which the Sponsor is a debtor in a case under title 11, United States Code, or similar federal or state law, except for payments made within a Plan Year with an annuity starting date that occurs on or after the date on which the Plan's enrolled actuary certifies that the Plan's AFTAP for that Plan Year is not less than 100 percent. In addition, during such period in which the Sponsor is a debtor, the Plan shall not make any payment for the purchase of an irrevocable commitment from an insurer to pay benefits or any other payment or transfer that is a prohibited payment, except for payments that occur on a date within a Plan Year that is on or after the date on which the Plan's enrolled actuary certifies that the Plan's AFTAP for that Plan Year is not less than 100 percent. The limitation set forth in this Section 13.3 does not apply to any payment of a benefit which under Code Section 411(a)(11) may be immediately distributed without the consent of the Member.

13.4 Provisions Applicable After Limitations Cease to Apply.

(a) Resumption of Prohibited Payments. If a limitation on prohibited payments under Section 13.1(a), 13.2(a) or 13.3 applied to the Plan as of a section 436 measurement date, but that limit no longer applies to the Plan as of a later section 436 measurement date, then that limitation does not apply to benefits with annuity starting dates that are on or after that later section 436 measurement date.

(b) Resumption of Benefit Accruals. If a limitation on benefit accruals under Section 13.2(c) applied to the Plan as of a section 436 measurement date, but that limitation no longer applies to the Plan as of a later section 436 measurement date, then benefit accruals shall resume prospectively and that limitation does not apply to benefit accruals that are based on service on or after that later section 436 measurement date, except as otherwise provided under the Plan. The Plan shall comply with the rules relating to partial years of participation and the prohibition on double proration under Department of Labor Regulation 29 CFR Section 2530.204-2(c) and (d).

(c) Shutdown and Other Unpredictable Contingent Event Benefits. If an unpredictable contingent event benefit with respect to an unpredictable contingent event that occurs during the Plan Year is not permitted to be paid after the occurrence of the event because of the limitation of Section 13.2(b), but is permitted to be paid later in the same Plan Year (as a result of additional contributions or pursuant to the enrolled actuary's certification of the AFTAP for the Plan Year that meets the requirements of Regulation Section 1.436-1(g)(5)(ii)(B)), then that unpredictable contingent event benefit shall be paid, retroactive to the period that benefit would have been payable under the terms of the Plan (determined without regard to Section 13.2(b)). If the unpredictable contingent event benefit does not become payable during the Plan Year in accordance with the preceding sentence, then the Plan is treated as if it does not provide for that benefit.

(d) Treatment of Plan Amendments That Do Not Take Effect. If a plan amendment does not take effect as of the effective date of the amendment because of the limitation of Section 13.1(b) or Section 13.2(c), but is permitted to take effect later in the same Plan Year (as a result of additional contributions or pursuant to the enrolled actuary's certification of the AFTAP for the Plan Year that meets the requirements of Regulation Section 1.436-1(g)(5)(ii)(C)), then the plan amendment must automatically take effect as of the first day of the Plan Year (or if later, the original effective date of the amendment). If the plan amendment cannot take effect during the same Plan Year, then it shall be treated as if it were never adopted, unless the plan amendment provides otherwise.

13.5 Notice Requirement. See ERISA Section 101(j) for rules requiring the plan administrator of a single employer defined benefit pension plan to provide a written notice to participants and beneficiaries within 30 days after certain specified dates if the plan has become subject to a limitation described in Section 13.1(a), 13.2 or 13.3.

13.6 Methods to Avoid or Terminate Benefit Limitations. See Code Sections 436(b)(2), (c)(2), (e)(2) and (f) and Regulation Section 1.436-1(f) for rules relating to employer contributions and other methods to avoid or terminate the application of the limitations set forth in Sections 13.1 through 13.3 for a plan year. In general, the methods a plan sponsor may use to avoid or terminate one or more of the benefit limitations under Sections 13.1 through 13.3 for a plan year include employer contributions and elections to increase the amount of plan assets which are taken into account in determining the AFTAP, making an employer contribution that is specifically designated as a current year contribution that is made to avoid or terminate application of certain of the benefit limitations, or providing security to the plan.

13.7 Special Rules.

(a) Rules of Operation for Periods Prior to and After Certification of Plan's AFTAP.

(1) In General. Code Section 436(h) and Regulation Section 1.436-1(h) set forth a series of presumptions that apply (A) before the Plan's enrolled actuary issues a certification of the Plan's AFTAP for the Plan Year, and (B) if the Plan's enrolled actuary does not issue a certification of the Plan's AFTAP for the Plan Year before the first day of the tenth month of the Plan Year (or if the Plan's enrolled actuary issues a range certification for the Plan Year pursuant to Regulation Section 1.436-1(h)(4)(ii) but does not issue a certification of the specific ATAP for the Plan by the last day of the Plan Year). For any period during which a presumption under Code Section 436(h) and Regulation Section 1.436-1(h) applies to the Plan, the limitations under Sections 13.1 through 13.3 are applied to the Plan as if the AFTAP for the Plan Year were the presumed AFTAP determined under the rules of Code Section 436(h) and Regulation Section 1.436-1(h)(1), (2) or (3). These presumptions are set forth in Sections 13.7(a)(2) through (4).

(2) Presumption of Continued Underfunding Beginning First Day of Plan Year. If a limitation under Section 13.1, 13.2 or 13.3 applied to the Plan on the last day of the preceding Plan Year, then, commencing on the first day of the current Plan Year and continuing until the Plan's enrolled actuary issues a certification of the AFTAP for the Plan for the current Plan Year, or if earlier, the date Section 13.7(a)(3) or 13.7(a)(4) applies to the Plan:

(A) The AFTAP of the Plan for the current Plan Year is presumed to be the AFTAP in effect on the last day of the preceding Plan Year; and

(B) The first day of the current Plan Year is a section 436 measurement date.

(3) Presumption of Underfunding Beginning First Day of Fourth Month. If the Plan's enrolled actuary has not issued a certification of the AFTAP for the Plan Year before the first day of the fourth month of the Plan Year and the Plan's AFTAP for the preceding Plan Year was either at least 60 percent but less than 70 percent or at least 80 percent but less than 90 percent, or is described in Regulation Section 1.436-1(h)(2)(ii), then, commencing on the first day of the fourth month of the current Plan Year and continuing until the Plan's enrolled actuary issues a certification of the AFTAP for the Plan for the current Plan Year, or if earlier, the date Section 13.7(a)(4) applies to the Plan:

(A) The AFTAP of the Plan for the current Plan Year is presumed to be the Plan's AFTAP for the preceding Plan Year reduced by ten percentage points; and

(B) The first day of the fourth month of the current Plan Year is a section 436 measurement date.

(4) Presumption of Underfunding On and After First Day of Tenth Month. If the Plan's enrolled actuary has not issued a certification of the AFTAP for the Plan Year before the first day of the tenth month of the Plan Year (or if the Plan's enrolled actuary has issued a range certification for the Plan Year pursuant to Regulation Section 1.436-1(h)(4)(ii) but has not issued a certification of the specific AFTAP for the Plan by the last day of the Plan Year), then, commencing on the first day of the tenth month of the current Plan Year and continuing through the end of the Plan Year:

(A) The AFTAP of the Plan for the current Plan Year is presumed to be less than 60 percent; and

(B) The first day of the tenth month of the current Plan Year is a section 436 measurement date.

(b) New Plans, Plan Termination, Certain Frozen Plans and Other Special Rules.

(1) First Five Plan Years. The limitations in Sections 13.1(b), 13.2(b) and 13.2(c) do not apply to a new plan for the first five plan years of the plan, determined under the rules of Code Section 436(i) and Regulation Section 1.436-1(a)(3)(i).

(2) Plan Termination. The limitations on prohibited payments in Sections 13.1(a), 13.2(a) and 13.3 do not apply to prohibited payments that are made to carry out the termination of the Plan in accordance with applicable law. Any other limitations under this Article 13 do not cease to apply as a result of termination of the Plan.

(3) Exception to Limitations on Prohibited Payments under Certain Frozen Plans. The limitations on prohibited payments set forth in Sections 13.1(a), 13.2(a) and 13.3 do not apply for a Plan Year if the terms of the Plan, as in effect for the period beginning September 1, 2005, and continuing through the end of the Plan Year, provide for no benefit accruals with respect to any Members. This Section 13.7(b)(3) shall cease to apply as of the date any benefits accrue under the Plan or the date on which a Plan amendment that increases benefits takes effect.

(4) Special Rules Relating to Unpredictable Contingent Event Benefits and Plan Amendments Increasing Benefit Liability. During any period in which none of the presumptions under Section 13.7(a) apply to the Plan and the Plan's enrolled actuary has not yet issued a certification of the Plan's AFTAP for the Plan Year, the limitations under Section 13.1(b) and Section 13.2(b) shall be based on the inclusive presumed AFTAP for the Plan, calculated in accordance with Regulation Section 1.436-1(g)(2)(iii).

(c) Special Rules under Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010.

(1) Payments under Social Security Leveling Options. For purposes of determining whether the limitations under Section 13.1(a) or 13.2(a) apply to payments under a

Social Security leveling option, within the meaning of Code Section 436(j)(3)(C)(i), the AFTAP for a Plan Year shall be determined in accordance with the "Special Rule for Certain Years" under Code Section 436(j)(3) and any Regulations or other published guidance thereunder issued by the IRS.

(2) Limitation on Benefit Accruals. For purposes of determining whether the accrual limitation under Section 13.2(c) applies to the Plan, the AFTAP for a Plan Year shall be determined in accordance with the "Special Rule for Certain Years" under Code Section 436(j)(3) (except as provided under Section 203(b) of the Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, if applicable).

(d) Interpretation of Provisions. The limitations imposed by this Article 13 shall be interpreted and administered in accordance with Code Section 436 and Regulation Section 1.436-1.

13.8 Definitions. The definitions in the following Regulations apply for purposes of Sections 13.1 through 13.7: Section 1.436-1(j)(1) defining adjusted funding target attainment percentage; Section 1.436-1(j)(2) defining annuity starting date; Section 1.436-1(j)(6) defining prohibited payment; Section 1.436-1(j)(8) defining section 436 measurement date; and Section 1.436-1(j)(9) defining an unpredictable contingent event and an unpredictable contingent event benefit.

13.9 Effective Date. The provisions of Sections 13.1 through 13.8 are effective for Plan Years beginning after December 31, 2007.

ARTICLE 14
RETIREE HEALTH CARE SEPARATE ACCOUNTS

14.1 Establishment. Effective February 1, 2020, a separate account within the meaning of Code Section 401(h) ("Separate Account") is established and maintained under the Plan to provide post-retirement medical, hospital, vision care and prescription drug benefits that are considered sickness, accident, hospitalization and medical expenses under Code Section 401(h) (hereinafter, "post-retirement health benefits") to participants under the El Paso Electric Company Retiree Welfare Benefits Plan ("Retiree Medical Plan") (and their eligible spouses and dependents) who are Members under the Plan and who satisfy the eligibility requirements set forth in Section 14.2. In no event shall the Plan discriminate in favor of officers, shareholders, supervisory employees or highly compensated employees with respect to post-retirement health benefits provided under this Article 14 or with respect to contributions to the Separate Account or any Key Employee Separate Accounts established under Section 14.3 (collectively, the "Separate Accounts"). The benefits and time periods with respect to which post-retirement health benefits provided under the Separate Accounts will be paid shall be determined under the Retiree Medical Plan, without Employer discretion as to the timing or amount of benefit payments. As used in this Article 14, "dependent" shall mean a child, as defined in Code Section 152(f)(1), of an eligible retiree, as determined under Section 14.2, who as of the end of the calendar year has not attained age 27; provided, however, that under the current terms of the Retiree Medical Plan, in general, dependents who have attained age 26 are not eligible.

14.2 Eligible Retirees. The Separate Accounts will be available to provide post-retirement health benefits under the Retiree Medical Plan for Members under the Plan (and their eligible spouses and dependents) (a) who are eligible for coverage under the Retiree Medical Plan, (b) who are non-collectively bargained employees who retire under the terms of the Plan and are eligible to receive retirement benefits under the Plan, (c) who are under age 60 as of January 1, 2020, and (d) who terminate employment on or after January 1, 2020. Post-retirement health benefits under the Retiree Medical Plan for all other retired employees will not be covered or funded by the Separate Accounts. Notwithstanding the foregoing, no amounts shall be payable from the Separate Accounts to the extent that such liabilities are funded by the Employer under a voluntary employees' beneficiary association or any other funding arrangement.

14.3 Key Employees. No amount shall be payable from the assets of the Separate Account established under Section 14.1 for post-retirement health benefits for an individual (or his eligible spouse and dependents) who at any time has been a Key Employee (as defined in Code Section 416(i)), and post-retirement health benefits for Key Employees shall be payable directly from the general assets of the Employer or another funding vehicle established by the Employer. The preceding provisions of this Section 14.3 notwithstanding, the Employer may establish and maintain "Key Employee Separate Accounts" under the Plan for the payment of post-retirement health benefits under the Retiree Medical Plan for Members who are Key Employees and who satisfy the eligibility requirements set forth in Section 14.2 (and their eligible spouses and dependents), and post-retirement health benefits shall be payable from each such Key Employee Separate Account only to such Key Employee for whom the Key Employee Separate Account is established (and his eligible spouse and dependents).

14.4 Funding.

(a) Reasonable and Ascertainable. Amounts contributed to the Separate Accounts shall be reasonable and ascertainable. Contributions to the Separate Accounts shall be determined using reasonable actuarial assumptions, which include consideration of the terms and coverage of the Retiree Medical Plan, the Retiree Medical Plan's funding, and any forfeitures arising due to employee turnover, deaths or items of like nature. In determining how much may be contributed to the Plan to provide post-retirement health benefits, the Plan's enrolled actuary may take into account reasonably projected increases in health care costs due to inflation and other factors. In no case shall Separate Account forfeitures prior to termination of the Plan serve to increase the benefits payable under the Retiree Medical Plan. Forfeitures of individual interests in Separate Accounts maintained under this Article 14 that occur prior to termination of the Plan must be applied as soon as possible to reduce Employer contributions to fund post-retirement health benefits under this Article 14.

(b) Subordinate Benefits. Post-retirement health benefits paid by the Separate Accounts shall be subordinate to the Plan's retirement benefits. Accordingly, subject to Section 14.4(a), the aggregate actual contributions to the Separate Accounts for providing post-retirement health benefits under the Retiree Medical Plan shall not exceed 25 percent of the total aggregate actual contributions made to the Plan (other than contributions to fund past service credits) after the date on which the Separate Account is established under Section 14.1 The

amount of any contribution returned to the Employer under Section 4.5 shall not be taken into account in applying the 25 percent limit on contributions to provide post-retirement health benefits.

14.5 Separate Account Contributions. The Employer shall designate which contributions to the Plan are being made for post-retirement health benefits at the time the contributions are made, and these contributions shall be credited to the Separate Accounts established under this Article 14. Although contributions to the Separate Accounts are currently provided entirely from Employer contributions, the Employer may, in the future, require Members to make contributions to the Separate Accounts established under this Article 14.

14.6 Commingling of Separate Account Assets for Investment Purposes. All contributions to the Separate Accounts may be commingled with Plan assets held for retirement benefits for investment and custody purposes, but, for recordkeeping purposes, all contributions to the Separate Accounts and earnings thereon, if any, together with all disbursements from the Separate Accounts, shall be recorded and accounted for in one or more Separate Accounts relating solely to the provision of post-retirement health benefits under the Retiree Medical Plan. If the Employer makes a contribution to the Trust that includes amounts allocable both to retirement benefits under the Plan and post-retirement health benefits under the Plan's Separate Accounts, the Employer shall clearly specify the portion of such contribution allocable to such retirement benefits and the portion allocable to such post-retirement health benefits allocable to each of the Plan's Separate Accounts.

14.7 Post-Retirement Health Benefits Not Vested. Neither Retiree Medical Plan nor Separate Account benefits (a) constitute any portion of a Member's "accrued benefit" under the Plan, (b) are subject to the vesting requirements of Code Section 411 or the vesting schedules set forth under Section 5.1, (c) are subject to protection under Code Section 411(d)(6) from reduction or elimination, or (d) are protected by corresponding provisions of ERISA. The Employer expressly reserves the right to change, reduce or eliminate the benefits provided under the Retiree Medical Plan (and the corresponding post-retirement health benefits provided under the Separate Accounts) at any time and in any fashion, and no person may rely on the future continuation of the Retiree Medical Plan (or the corresponding post-retirement health benefits provided under the Separate Accounts). Post-retirement health benefits shall be provided under the Plan only to the extent they can be paid from assets then credited to the Separate Accounts.

14.8 Exclusive Benefit. Separate Account assets shall be used solely for the purpose of (a) providing post-retirement health benefits for Members under the Plan who satisfy the eligibility requirements set forth in Section 14.2, and (b) paying any necessary or appropriate expenses attributable to the administration of the Separate Accounts. No part of the corpus or income of the Separate Accounts shall be used for, or diverted to, any purpose other than the provision of post-retirement health benefits at any time prior to the satisfaction of all liabilities for post-retirement health benefits under this Article 14. Notwithstanding Code Section 401(a)(2), upon the satisfaction of all post-retirement health benefit liabilities incurred with respect eligible retirees, as determined under Section 14.2, any amounts that remain in the Separate Accounts shall be returned to the Employer by the Trustee. If the Separate Accounts in their entireties are ever terminated (even though the Plan continues in existence) or if the Plan in

its entirety is ever terminated, upon the satisfaction of all liabilities arising out of the operation of the Separate Accounts, any surplus remaining in the Separate Accounts shall be returned to the Employer to the extent required by Code Section 401(h).

14.9 Modification, Amendment and Termination. The Employer reserves the right to modify, amend or terminate the Retiree Medical Plan at any time. The establishment and operation of the Separate Accounts do not obligate the Employer in any way to continue to maintain any health care plans of any nature or to provide post-retirement health care coverage of any kind. In the event that the Employer terminates post-retirement health coverage, this Plan shall have no liability to provide further health coverage for current or future retirees, for purposes of determining the amount to be returned to the Employer under Section 14.8. No amendment, modification or termination of the Retiree Medical Plan, nor change in Employer contributions under this Article 14, shall retroactively, adversely affect any participant's benefit under the Retiree Medical Plan.

IN WITNESS WHEREOF, this amended and restated Plan has been executed this 14 day of August, 2020.

EL PASO ELECTRIC COMPANY

By: _____
Officer

2021

Summary of Benefits

Humana Group Medicare Advantage PPO Plan
PPO 079/388

El Paso Electric Company

Humana.

Our service area includes specific counties within the United States, Puerto Rico and the Virgin Islands.

Let's talk about the **Humana Group Medicare Advantage PPO** Plan.

Find out more about the Humana Group Medicare Advantage PPO plan – including the services it covers – in this easy-to-use guide.

The benefit information provided is a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. For a complete list of services we cover, refer to the "Evidence of Coverage".

To be eligible

To join the Humana Group Medicare Advantage PPO plan, you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area.

Plan name:

Humana Group Medicare Advantage PPO plan

How to reach us:

Members should call toll-free **1-866-396-8810** for questions **(TTY/TDD 711)**

Call Monday – Friday, 8 a.m. - 9 p.m. Eastern Time.

Or visit our website: **Humana.com**

Humana Group Medicare Advantage PPO plan has a network of doctors, hospitals, and other providers. For more information, please call Group Medicare Customer Care.

A healthy partnership

Get more from your plan — with extra services and resources provided by Humana!

Monthly Premium, Deductible and Limits

	IN-NETWORK	OUT-OF-NETWORK
PLAN COSTS		
Monthly premium You must keep paying your Medicare Part B premium.	For information concerning the actual premiums you will pay, please contact your employer/union group.	
Medical deductible	**$330** per year for some combined in- and out-of-network services	**$330** per year for some combined in- and out-of-network services
Maximum out-of-pocket responsibility The most you pay for copays, coinsurance and other costs for medical services for the year.	**In-Network Maximum Out-of-Pocket** **$2,000** out-of-pocket limit for Medicare-covered services. The following services do not apply to the maximum out-of-pocket: Part D Pharmacy, COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Fitness Program ; Health Education Services ; Meal Benefit ; Smoking Cessation (Additional) and the Plan Premium. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.	**Combined In and Out-of-Network Maximum Out-of-Pocket** **$2,000** out-of-pocket limit for Medicare-covered services. In-Network Exclusions: Part D Pharmacy, COVID-19 Care Package ; COVID-19 Testing ; COVID-19 Treatment ; Fitness Program ; Health Education Services ; Meal Benefit ; Smoking Cessation (Additional) and the Plan Premium do not apply to the combined maximum out-of-pocket. Out-of-Network Exclusions: Part D Pharmacy, COVID-19 Testing ; COVID-19 Treatment ; Worldwide Coverage and the Plan Premium do not apply to the combined maximum out-of-pocket. Your limit for services received from in-network providers will count toward this limit. If you reach the limit on out-of-pocket costs, we will pay the full cost for the rest of the year on covered hospital and medical services.

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
ACUTE INPATIENT HOSPITAL CARE		
Our plan covers an unlimited number of days for an inpatient hospital stay. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital.	**$250** per admit	**$250** per admit
OUTPATIENT HOSPITAL COVERAGE		
Outpatient hospital visits	**$0** to **$35** copay	**$0** to **$35** copay
Ambulatory surgical center	**$10** copay	**$10** copay
DOCTOR OFFICE VISITS		
Primary care provider (PCP)	**$15** copay	**$15** copay
Specialists	**$25** copay	**$25** copay
PREVENTIVE CARE		
Including: Annual Wellness Visit, flu vaccine, colorectal cancer and breast cancer screenings. Any additional preventive services approved by Medicare during the contract year will be covered.	**Covered at no cost.**	**$0** copay for Medicare-covered preventive services **$0** copay for a supplemental annual physical exam
EMERGENCY CARE		
Emergency room If you are admitted to the hospital within 24 hours for the same condition, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs.	**$75** copay for Medicare-covered emergency room visit(s)	**$75** copay for Medicare-covered emergency room visit(s)
Urgently needed services Urgently needed services are care provided to treat a non-emergency, unforeseen medical illness, injury or condition that requires immediate medical attention.	**$15** to **$40** copay	**$15** to **$40** copay

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES, LABS AND IMAGING		
Diagnostic radiology	**$10** to **$25** copay	**$10** to **$25** copay
Lab services	**$0** copay	**$0** copay
Diagnostic tests and procedures	**$0** to **$40** copay	**$0** to **$40** copay
Outpatient X-rays	**$10** to **$40** copay	**$10** to **$40** copay
Radiation therapy	**$10** to **$25** copay	**$10** to **$25** copay
HEARING SERVICES		
Medicare-covered hearing	**$25** copay	**$25** copay
Routine hearing	• $2000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years.	• $2000 combined in and out of network maximum benefit coverage amount for both hearing aid(s) (all types) up to 2 every 3 years. • Benefits received out-of-network are subject to any in-network benefit maximums, limitations, and/or exclusions.
DENTAL SERVICES		
Medicare-covered dental	**$25** copay	**$25** copay
VISION SERVICES		
Medicare-covered vision services	**$25** copay	**$25** copay
Medicare-covered diabetic eye exam	**$0** copay	**$0** copay
Medicare-covered glaucoma screening	**$0** copay	**$0** copay
Medicare-covered eyewear (post-cataract)	**$25** copay	**$25** copay

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
MENTAL HEALTH SERVICES		
Inpatient The inpatient hospital care limit applies to inpatient mental services provided in a general hospital. Except in an emergency, your doctor must tell the plan that you are going to be admitted to the hospital. 190 day lifetime limit in a psychiatric facility	**$250** per admit	**$250** per admit
Outpatient group and individual therapy visits	**$15** to **$40** copay	**$15** to **$40** copay
SKILLED NURSING FACILITY		
Our plan covers up to 100 days in a SNF. No 3-day hospital stay is required. Plan pays $0 after 100 days	**$0** copay per day for days 1-20 **$30** copay per day for days 21-100	**$0** copay per day for days 1-20 **$30** copay per day for days 21-100
PHYSICAL THERAPY		
	$25 to **$35** copay	**$25** to **$35** copay
AMBULANCE		
Per date of service regardless of the number of trips. Limited to Medicare-covered transportation.	**$10** copay	**$10** copay
PART B PRESCRIPTION DRUGS		
	$0 to **$10** copay	**$0** to **$10** copay
ACUPUNCTURE SERVICES		
Medicare-covered acupuncture	**$25** copay Limit 20 visit(s) per year	**$25** copay Limit 20 visit(s) per year
ALLERGY		
Allergy shots & serum	**$15** to **$25** copay	**$15** to **$25** copay
CHIROPRACTIC SERVICES		
Medicare-covered chiropractic visit(s)	**$20** copay	**$20** copay

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
COVID-19		
Testing and Treatment	**$0** copay for testing and treatment services for COVID-19	
Health Essentials Kit	Kit includes over the counter items useful for preventing the spread of COVID-19 and other viruses. Limited one per year.	
DIABETES MANAGEMENT TRAINING		
	$0 copay	**$0** copay
FOOT CARE (PODIATRY)		
Medicare-covered foot care	**$25** copay	**$25** copay
HOME HEALTH CARE		
	$0 copay	**$0** copay
MEDICAL EQUIPMENT/SUPPLIES		
Durable medical equipment (like wheelchairs or oxygen)	**$10** copay	**$10** copay
Medical supplies	**$10** copay	**$10** copay
Prosthetics (artificial limbs or braces)	**$10** copay	**$10** copay
Diabetes monitoring supplies	**$0** to **$10** copay	**$0** to **$10** copay
OUTPATIENT SUBSTANCE ABUSE		
Outpatient group and individual substance abuse treatment visits	**$15** to **$40** copay	**$15** to **$40** copay
REHABILITATION SERVICES		
Occupational and speech therapy	**$25** to **$35** copay	**$25** to **$35** copay
Cardiac rehabilitation	**$25** to **$35** copay	**$25** to **$35** copay
Pulmonary rehabilitation	**$25** to **$30** copay	**$25** to **$30** copay
RENAL DIALYSIS		
Renal dialysis	**$10** copay	**$10** copay
Kidney disease education services	**$0** copay	**$0** copay
TELEHEALTH SERVICES (in addition to Original Medicare)		
Primary care provider (PCP)	**$0** copay	Not Covered
Specialist	**$25** copay	Not Covered

Note: *some services require prior authorization.*

Covered Medical and Hospital Benefits

	IN-NETWORK	OUT-OF-NETWORK
Urgent care services	**$0** copay	Not Covered
Substance abuse or behavioral health services	**$0** copay	Not Covered
FITNESS AND WELLNESS		
	SilverSneakers® Fitness Program - Basic fitness center membership including fitness classes.	
HOSPICE You must get care from a Medicare-certified hospice. You must consult with your plan before you select hospice.		

Note: *some services require prior authorization.*

Notes

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618.
  If you need help filing a grievance, call **1-866-396-8810** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-866-396-8810 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you.
1-866-396-8810 (TTY: 711)
Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog - Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee haní'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

GCHJV5REN 0220

Find out **more**

You can see your plan's provider directory at **Humana.com** or call us at the number listed at the beginning of this booklet and we will send you one.

Humana is a Medicare Advantage PPO plan with a Medicare contract. Enrollment in this Humana plan depends on contract renewal.

If you want to compare our plan with other Medicare health plans, you can call your employer or union sponsoring this plan to find out if you have other options through them.

If you want to know more about the coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Humana®

Humana.com

PPO 079/388

5564

El Paso Electric Company

Your Group Life Insurance Plan

Identification No. 415381 021

Underwritten by Unum Life Insurance Company of America

11/12/2013

CERTIFICATE OF COVERAGE

Unum Life Insurance Company of America (referred to as Unum) welcomes you as a client.

This is your certificate of coverage as long as you are eligible for coverage and you become insured. You will want to read it carefully and keep it in a safe place.

Unum has written your certificate of coverage in plain English. However, a few terms and provisions are written as required by insurance law. If you have any questions about any of the terms and provisions, please consult Unum's claims paying office. Unum will assist you in any way to help you understand your benefits.

If the terms and provisions of the certificate of coverage (issued to you) are different from the Summary of Benefits (issued to the Employer), the Summary of Benefits will govern. The Summary of Benefits may be changed in whole or in part. Only an officer or registrar of Unum can approve a change. The approval must be in writing and endorsed on or attached to the Summary of Benefits. Any other person, including an agent, may not change the Summary of Benefits or waive any part of it.

The Summary of Benefits is delivered in and is governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

For purposes of effective dates and ending dates under the group Summary of Benefits, all days begin at 12:01 a.m. and end at 12:00 midnight at the Employer's address.

Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

The insurance Summary of Benefits under which this certificate is issued is not a policy of Workers' Compensation Insurance. You should consult your Employer to determine whether your Employer is a subscriber to the Workers' Compensation system.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call Unum's toll-free telephone number for information or to make a complaint at:

1-800-321-3889
OPTION NUMBER 2

You may also write to Unum at:

Deborah J. Jewett, Manager
Customer Relations
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may also write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance (TDI).

ATTACH THIS NOTICE TO YOUR CERTIFICATE OF COVERAGE:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de Unum's para informacion o para someter una queja al:

1-800-321-3889
OPCION NUMERO 2

Usted tambien puede escribir a Unum:

Deborah J. Jewett
Gerente de Relaciones al
Cliente
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas
P.O. Box 149104
Austin, TX 78714-9104
FAX: (512) 475-1771

Web: http://www.tdi.state.tx.us

E-mail: ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS:

Si tiene una disputa concemiente a su prima o a un reclamo, debe comunicarse con el la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI).

SUJETE ESTA NOTICIA A SU CERTIFICADO DE BENEFICIOS:

Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

TABLE OF CONTENTS

BENEFITS AT A GLANCE

LIFE INSURANCE PLAN

This life insurance plan provides financial protection for your beneficiary(ies) by paying a benefit in the event of your death. The amount your beneficiary(ies) receive(s) is based on the amount of coverage in effect just prior to the date of your death according to the terms and provisions of the plan.

EMPLOYER'S ORIGINAL PLAN
EFFECTIVE DATE: January 1, 2014

IDENTIFICATION NUMBER: 415381 021

ELIGIBLE GROUP(S):

Retirees

WHO PAYS FOR THE COVERAGE:

Your Employer pays the cost of your coverage.

LIFE INSURANCE BENEFIT:

AMOUNT OF LIFE INSURANCE FOR YOU

$10,000

SOME LOSSES MAY NOT BE COVERED UNDER THIS PLAN.

OTHER FEATURES:

Conversion

Continuity of Coverage

The above items are only highlights of this plan. For a full description of your coverage, continue reading your certificate of coverage section.

CLAIM INFORMATION

LIFE INSURANCE

WHEN DO YOU OR YOUR AUTHORIZED REPRESENTATIVE NOTIFY UNUM OF A CLAIM?

We encourage you or your authorized representative to notify us as soon as possible, so that a claim decision can be made in a timely manner.

Written notice and proof of claim must be sent no later than 90 days after the date of death.

If it is not possible to give proof within this time limit, it must be given no later than 1 year after the proof is required as specified above. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give us proof of claim.

The claim form is available from your Employer, or you or your authorized representative can request a claim form from us. If you or your authorized representative does not receive the form from Unum within 15 days of the request, send Unum written proof of claim without waiting for the form.

WHAT INFORMATION IS NEEDED AS PROOF OF YOUR CLAIM?

Proof of claim, provided at your or your authorized representative's expense, must show the cause of death. Also a certified copy of the death certificate must be given to us.

In some cases, you will be required to give Unum authorization to obtain additional medical and non-medical information as part of your proof of claim. Unum will deny your claim if the appropriate information is not submitted.

WHEN CAN UNUM REQUEST AN AUTOPSY?

Unum will have the right and opportunity to request an autopsy where not forbidden by law.

HOW DO YOU DESIGNATE OR CHANGE A BENEFICIARY? (Beneficiary Designation)

At the time you become insured, you should name a beneficiary on your enrollment form for your death benefits under your life insurance. You may change your beneficiary at any time by filing a form approved by Unum with your Employer. The new beneficiary designation will be effective as of the date you sign that form. However, if we have taken any action or made any payment before your Employer receives that form, that change will not go into effect.

It is important that you name a beneficiary and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, or if your named beneficiary is disqualified, your death benefit will be paid to your estate.

Instead of making a death payment to your estate, Unum has the right to make payment to the first surviving family members of the family members in the order listed below:

- spouse;
- child or children;
- mother or father; or
- sisters or brothers.

If we are to make payments to a beneficiary who lacks the legal capacity to give us a release, Unum may pay up to $2,000 to the person or institution that appears to have assumed the custody and main support of the beneficiary. This payment made in good faith satisfies Unum's legal duty to the extent of that payment and Unum will not have to make payment again.

Also, at Unum's option, we may pay up to $1,000 to the person or persons who, in our opinion, have incurred expenses for your last sickness and death.

HOW WILL UNUM MAKE PAYMENTS?

If your life claim is at least $10,000, Unum will make available to the beneficiary a **retained asset account** (the Unum Security Account).

Payment for the life claim may be accessed by writing a draft in a single sum or drafts in smaller sums. The funds for the draft or drafts are fully guaranteed by Unum.

If the life claim is less than $10,000, Unum will pay it in one lump sum to your beneficiary.

Also, your beneficiary may request the life claim to be paid according to one of Unum's other settlement options. This request must be in writing in order to be paid under Unum's other settlement options.

WHAT HAPPENS IF UNUM OVERPAYS YOUR CLAIM?

Unum has the right to recover any overpayments due to:

- fraud; and
- any error Unum makes in processing a claim.

You must reimburse us in full. We will determine the method by which the repayment is to be made.

Unum will not recover more money than the amount we paid you.

WHAT ARE YOUR ASSIGNABILITY RIGHTS FOR THE DEATH BENEFITS UNDER YOUR LIFE INSURANCE? (Assignability Rights)

The rights provided to you by the plan for life insurance are owned by you, unless:

- you have previously assigned these rights to someone else (known as an "assignee"); or
- you assign your rights under the plan(s) to an assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- the assignment is in writing, signed by you, and acceptable to us in form; and
- a signed or certified copy of the written assignment has been received and registered by us at our home office.

We will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan(s') provisions before receiving and registering an assignment.

GENERAL PROVISIONS

WHAT IS THE CERTIFICATE OF COVERAGE?

This certificate of coverage is a written statement prepared by Unum and may include attachments. It tells you:

- the coverage for which you may be entitled;
- to whom Unum will make a payment; and
- the limitations, exclusions and requirements that apply within a plan.

WHEN ARE YOU ELIGIBLE FOR COVERAGE?

The date you are eligible for coverage is the later of:

- the plan effective date; or
- the date you retire.

WHEN DOES YOUR COVERAGE BEGIN?

Your Employer pays 100% of the cost of your coverage. You will be covered at 12:01 a.m. on the date you are eligible for coverage.

WHEN DOES YOUR COVERAGE END?

Your coverage under the Summary of Benefits or a plan ends on the earliest of:

- the date the Summary of Benefits or a plan is cancelled;
- the date you no longer are in an eligible group;
- the date your eligible group is no longer covered; or
- the last day of the period for which any required contributions are made.

Unum will provide coverage for a payable claim which occurs while you are covered under the Summary of Benefits or plan.

WHAT ARE THE TIME LIMITS FOR LEGAL PROCEEDINGS?

You or your authorized representative can start legal action regarding a claim 60 days after proof of claim has been given and up to 3 years from the time proof of claim is required, unless otherwise provided under federal law.

HOW CAN STATEMENTS MADE IN YOUR APPLICATION FOR THIS COVERAGE BE USED?

Unum considers any material statements you or your Employer make in signed application for coverage or an evidence of insurability form a representation and not a warranty. If any of the material statements you or your Employer make are not complete and/or not true at the time they are made, we can:

- reduce or deny any claim; or
- cancel your coverage from the original effective date.

As a basis for doing this, we will use only statements made in an application signed by the Employer, or an application or evidence of insurability form signed by you, a copy of which has been given to you or your beneficiary, if any.

Except in the case of fraud, Unum can take action only in the first 2 years coverage is in force.

If the Employer gives us information about you that is incorrect, we will:

- use the facts to decide whether you have coverage under the plan and in what amounts; and
- make a fair adjustment of the premium.

HOW WILL UNUM HANDLE INSURANCE FRAUD?

Unum wants to ensure you and your Employer do not incur additional insurance costs as a result of the undermining effects of insurance fraud. Unum promises to focus on all means necessary to support fraud detection, investigation, and prosecution.

It is a crime if you knowingly, and with intent to injure, defraud or deceive Unum, or provide any information, including filing a claim, that contains any false, incomplete or misleading information. These actions, as well as submission of materially false information, will result in denial of your claim, and are subject to prosecution and punishment to the full extent under state and/or federal law. Unum will pursue all appropriate legal remedies in the event of insurance fraud.

DOES THE SUMMARY OF BENEFITS REPLACE OR AFFECT ANY WORKERS' COMPENSATION OR STATE DISABILITY INSURANCE?

The Summary of Benefits does not replace or affect the requirements for coverage by any workers' compensation or state disability insurance.

DOES YOUR EMPLOYER ACT AS YOUR AGENT OR UNUM'S AGENT?

For the purposes of the Summary of Benefits, your Employer acts on its own behalf or as your agent. Under no circumstances will your Employer be deemed the agent of Unum.

LIFE INSURANCE

BENEFIT INFORMATION

WHEN WILL YOUR BENEFICIARY RECEIVE PAYMENT?

Your beneficiary(ies) will receive payment when Unum approves your death claim.

WHAT DOCUMENTS ARE REQUIRED FOR PROOF OF DEATH?

Unum will require a certified copy of the death certificate, enrollment documents and a Notice and Proof of Claim form.

HOW MUCH WILL UNUM PAY YOUR BENEFICIARY IF UNUM APPROVES YOUR DEATH CLAIM?

Unum will determine the payment according to the amount of insurance shown in the LIFE INSURANCE **"BENEFITS AT A GLANCE"** page.

WHAT INSURANCE IS AVAILABLE WHEN COVERAGE ENDS? (Conversion Privilege)

When coverage ends under the plan, you can convert your coverage to an individual life policy, without evidence of insurability. The maximum amount that you can convert is the amount you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date:

- your coverage terminates; or
- you no longer are eligible to participate in the coverage of the plan.

Converted insurance may be of any type of the level premium whole life plans then in use by Unum. You may elect one year of Preliminary Term insurance under the level premium whole life policy. The individual policy will not contain disability or other extra benefits.

WHAT LIMITED CONVERSION IS AVAILABLE IF THE SUMMARY OF BENEFITS OR THE PLAN IS CANCELLED? (Conversion Privilege)

You may convert a limited amount of life insurance if you have been insured under your Employer's group plan with Unum for at least five (5) years and the Summary of Benefits or the plan:

- is cancelled with Unum; or
- changes so that you no longer are eligible.

The individual life policy maximum will be the lesser of:

- $10,000; or
- your coverage amount under the plan less any amount that becomes available under any other group life plan offered by your Employer within 31 days after the date the Summary of Benefits or the plan is cancelled.

PREMIUMS

Premiums for the converted insurance will be based on:

- your then attained age on the effective date of the individual life policy;
- the type and amount of insurance to be converted;
- Unum's customary rates in use at that time; and
- the class of risk to which you belong.

If the premium payment has been made, the individual life policy will be effective at the end of the 31 day conversion application period.

DEATH DURING THE THIRTY-ONE DAY CONVERSION APPLICATION PERIOD

If you die within the 31 day conversion application period, Unum will pay the beneficiary(ies) the amount of insurance that could have been converted. This coverage is available whether or not you have applied for an individual life policy under the conversion privilege.

APPLYING FOR CONVERSION

Ask your Employer for a conversion application form which includes cost information.

When you complete the application, send it with the first premium amount to:

Unum - Conversion Unit
2211 Congress Street
Portland, Maine 04122-1350
1-800-343-5406

WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?

Your plan does not cover any losses where death is caused by, contributed to by, or results from:

- suicide occurring within 24 months after your initial effective date of insurance; and
- suicide occurring within 24 months after the date any increases or additional insurance becomes effective for you.

The suicide exclusion will apply to any amounts of insurance for which you pay all or part of the premium.

The suicide exclusion also will apply to any amount that is subject to evidence of insurability requirements and Unum approves the evidence of insurability form and the amount you applied for at that time.

LIFE INSURANCE

OTHER BENEFIT FEATURES

WHAT IF YOU ARE NOT IN ACTIVE EMPLOYMENT WHEN YOUR EMPLOYER CHANGES GROUP INSURANCE CARRIERS TO UNUM? (CONTINUITY OF COVERAGE)

Unum will provide coverage for you if you were covered by the prior policy on the day before the effective date of this Summary of Benefits, and if you would be eligible for coverage under this Summary of Benefits if you were in active employment on the effective date of this Summary of Benefits.

If you are on a covered layoff or leave of absence on the effective date of this Summary of Benefits, we will consider your layoff or leave of absence to have started on that date, and coverage for you under this provision will continue for the layoff or leave of absence period provided in this Summary of Benefits, or the layoff or leave of absence period remaining under the prior policy on the effective date of this Summary of Benefits, whichever period is shorter.

If you are absent from work due to injury or sickness on the effective date of this Summary of Benefits, then coverage under this provision will continue until the earliest of the date:

- you are no longer injured or sick,
- you return to active employment,
- you are approved for a disability extension of benefits or accrued liability under the prior policy, including premium waiver, or
- your employment ends.

Also, if you incur a covered loss but are not in active employment under this Summary of Benefits, any benefits payable under this Summary of Benefits will be limited to the amount that would have been paid by the prior carrier. Unum will reduce your payment by any amount for which the prior carrier is liable.

Coverage for you is subject to payment of required premium and all other terms of this Summary of Benefits.

GLOSSARY

EMPLOYER means the Employer/Applicant named in the Application For Participation in the Select Group Insurance Trust, on the first page of the Summary of Benefits and in all amendments. It includes any division, subsidiary or affiliated company named in the Summary of Benefits.

GRACE PERIOD means the period of time following the premium due date during which premium payment may be made.

INSURED means any person covered under a plan.

PAYABLE CLAIM means a claim for which Unum is liable under the terms of the Summary of Benefits.

PLAN means a line of coverage under the Summary of Benefits.

RETAINED ASSET ACCOUNT is an interest bearing account established through an intermediary bank in the name of your beneficiary, as owner.

RETIREE means a person who was in active employment in the United States with the Employer just prior to their date of retirement.

TRUST means the policyholder trust named on the first page of the Summary of Benefits and all amendments to the policy.

WE, US and **OUR** means Unum Life Insurance Company of America.

YOU means a person who is eligible for retiree coverage under this plan.

THE FOLLOWING NOTICES AND CHANGES TO YOUR COVERAGE ARE REQUIRED BY THE STATE OF WASHINGTON. PLEASE READ CAREFULLY.

If you have a complaint about your insurance you may contact Unum at 1-800-321-3889, or the department of insurance in your state of residence. Links to the websites of each state department of insurance can be found at www.naic.org.

Si usted tiene alguna queja acerca de su seguro puede comunicarse con Unum al 1-800-321-3889, o al departamento de seguros de su estado de residencia. Puede encontrar enlaces a los sitios web de los departamentos de seguros de cada estado en www.naic.org.

If you are a resident of one of the states noted below, and the provisions referenced below appear in your Certificate in a form less favorable to you as an insured, they are amended as follows:

If you had group life coverage in place with your employer through another carrier when your employer changed carriers to Unum, your prior coverage may be continued under the Unum plan to the extent the laws of your resident state require such right to continue and within the design limits of the Unum plan.

Full effect will be given to your state's civil union, domestic partner and same sex marriage laws to the extent they apply to you under a group insurance policy issued in another state.

For residents of Washington

The ***WILL UNUM ACCELERATE YOUR OR YOUR DEPENDENT'S DEATH BENEFIT FOR THE PLAN IF YOU OR YOUR DEPENDENT BECOMES TERMINALLY ILL?*** **(Accelerated Benefit)** in the **Life Insurance Benefit Information** section is amended by changing the life expectancy requirement to 24 months or less, or such longer period as stated in the policy.

The ***WHAT LOSSES ARE NOT COVERED UNDER YOUR PLAN?*** provision in the **Life Insurance Benefit Information** section is amended to remove any exclusion for death caused by suicide.

ERISA

Additional Summary Plan Description Information

If this Summary of Benefits provides benefits under a Plan which is subject to the Employee Retirement Income Security Act of 1974 (ERISA), the following provisions apply. These provisions, together with your certificate of coverage, constitute the summary plan description. The summary plan description and the Summary of Benefits constitute the Plan. Benefit determinations are controlled exclusively by the Summary of Benefits, your certificate of coverage and the information contained in this document.

Name of Plan:
El Paso Electric Company Welfare Benefits Plan

Name and Address of Employer:
El Paso Electric Company
100 **N**. Stanton
El Paso, Texas
79901

Plan Identification Number:
a. Employer IRS Identification #: 74-0607870
b. Plan #: 510

Type of Welfare Plan:
Life

Type of Administration:
The Plan is administered by the Plan Administrator. Benefits are administered by the insurer and provided in accordance with the insurance Summary of Benefits issued to the Plan.

ERISA Plan Year Ends:
December 31

Plan Administrator, Name, Address, and Telephone Number:
El Paso Electric Company
100 N. Stanton
El Paso, Texas
79901
(915) 543-5985

El Paso Electric Company is the Plan Administrator and named fiduciary of the Plan, with authority to delegate its duties. The Plan Administrator may designate Trustees of the Plan, in which case the Administrator will advise you separately of the name, title and address of each Trustee.

Agent for Service of Legal Process on the Plan:
El Paso Electric Company
100 N. Stanton
El Paso, Texas
79901

Service of legal process may also be made upon the Plan Administrator, or a Trustee of the Plan, if any.

Funding and Contributions:

The Plan is funded by insurance issued by Unum Life Insurance Company of America, 2211 Congress Street, Portland, Maine 04122 (hereinafter referred to as "Unum") under identification number 415381 021. Contributions to the Plan are made as stated under "WHO PAYS FOR THE COVERAGE" in the Certificate of Coverage.

EMPLOYER'S RIGHT TO AMEND THE PLAN

The Employer reserves the right, in its sole and absolute discretion, to amend, modify, or terminate, in whole or in part, any or all of the provisions of this Plan (including any related documents and underlying policies), at any time and for any reason or no reason. Any amendment, modification, or termination must be in writing and endorsed on or attached to the Plan.

EMPLOYER'S RIGHT TO REQUEST SUMMARY OF BENEFITS CHANGE

The Employer can request a Summary of Benefits change. Only an officer or registrar of Unum can approve a change. The change must be in writing and endorsed on or attached to the Summary of Benefits.

MODIFYING OR CANCELLING THE SUMMARY OF BENEFITS OR A PLAN UNDER THE SUMMARY OF BENEFITS

The Summary of Benefits or a plan under the Summary of Benefits can be cancelled:

- by Unum; or
- by the Employer.

Unum may cancel or modify the Summary of Benefits or a plan if:

- there is less than 100% participation of those eligible employees for an Employer paid plan; or
- there is less than 75% participation of those eligible employees who pay all or part of the premium for a plan; or
- the Employer does not promptly provide Unum with information that is reasonably required; or
- the Employer fails to perform any of its obligations that relate to this Summary of Benefits; or
- fewer than 10 employees are insured under a plan; or
- the premium is not paid in accordance with the provisions of the Summary of Benefits that specify whether the Employer, the employee, or both, pay the premiums; or
- the Employer does not promptly report to Unum the names of any employees who are added or deleted from the eligible group; or
- Unum determines that there is a significant change, in the size, occupation or age of the eligible group as a result of a corporate transaction such as a merger, divestiture, acquisition, sale, or reorganization of the Employer and/or its employees; or

- the Employer fails to pay any premium within the 45 day grace period.

If Unum cancels or modifies the Summary of Benefits or a plan, for reasons other than the Employer's failure to pay premium, a written notice will be delivered to the Employer at least 31 days prior to the cancellation date or modification date. The Employer may cancel the Summary of Benefits or plan if the modifications are unacceptable.

If any portion of the premium is not paid during the grace period, Unum will either cancel or modify the Summary of Benefits or a plan automatically at the end of the grace period. The Employer is liable for premium for coverage during the grace period. The Employer must pay Unum all premium due for the full period each plan is in force.

The Employer may cancel the Summary of Benefits or a plan by written notice delivered to Unum at least 31 days prior to the cancellation date. When both the Employer and Unum agree, the Summary of Benefits or a plan can be cancelled on an earlier date. If Unum or the Employer cancels the Summary of Benefits or a plan, coverage will end at 12:00 midnight on the last day of coverage.

If the Summary of Benefits or a plan is cancelled, the cancellation will not affect a payable claim.

HOW TO FILE A CLAIM

If you wish to file a claim for benefits, you should follow the claim procedures described in your insurance certificate. To complete your claim filing, Unum must receive the claim information it requests from you (or your authorized representative), your attending physician and your Employer. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Unum directly.

CLAIMS PROCEDURES

In the event that your claim is denied, either in full or in part, Unum will notify you in writing within 90 days after your claim was filed. Under special circumstances, Unum is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Unum indicating the reason for the delay and the date you may expect a final decision. Unum's notice of denial shall include:

- the specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- a description of any additional material or information necessary to complete the claim and why that material or information is necessary; and
- a description of the Plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Unum on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

APPEAL PROCEDURES

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Unum's notice of denial. You have the right to:

- submit a request for review, in writing, to Unum;
- upon request and free of charge, reasonable access to and copies of, all relevant documents as defined by applicable U.S. Department of Labor regulations; and
- submit written comments, documents, records and other information relating to the claim to Unum.

Unum will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the Plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those Summary of Benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

YOUR RIGHTS UNDER ERISA

As a participant in this Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For Insurers declared insolvent or impaired on or after September 1 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the Texas Insurance Code, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:
- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:

1. The policyholder has a policy with a company domiciled in Texas;
2. The policyholder's state of residence has a similar guaranty association; and
3. The policyholder is not eligible for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:
- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:
- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:
- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities:
- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:
$300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health
Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, TX 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
800-252-3439 or www.tdi.state.tx.us