GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

125 CAFETERIA PLAN
Exhibit C

Summary Plan Document

Administered by Public Employees Health Program (PEHP)
560 East 200 South, Suite 110, Salt Lake City, Utah 84102-2004

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INTRODUCTION

Most of us have health care expenses that health insurance does not cover. In addition, many of us pay a considerable amount of money each year for dependent day care expenses. These out-of-pocket expenses take a big bite out of our take home pay. That's why your Employer has expanded its employee benefits program by offering THE 125 CAFETERIA PLAN, administered by the Public Employees Health Program (PEHP). The Cafeteria Plan saves you money and helps your pay go farther.

This document briefly describes advantages and special rules that apply to the Cafeteria Plan. Please read it carefully. It will help you understand how the program works so that you can take full advantage of its many attractive features. If there is anything you do not understand, contact the PEHP, at (801) 366-7503 or (800) 753-7751.

HOW THE CAFETERIA PLAN WORKS

The Cafeteria Plan program increases your spendable income by reducing your taxes. It accomplishes this by allowing you to use "before-tax" dollars to pay for specific out-of-pocket health care and dependent day care expenses. Employees who do not participate in the Cafeteria Plan program will pay the same type of expenses with "after-tax" dollars.

The difference between "before-tax" and "after-tax" dollars is very important. "Before-tax" dollars is your gross pay before Federal, State, and Social Security taxes are calculated and deducted. "After-tax" dollars is the net amount remaining after all taxes have been deducted from your pay. It makes good sense to use "before-tax" dollars to pay for eligible health care and dependent day care expenses.

CAUTION SHOULD BE USED IN DETERMINING THE AMOUNT TO BE DEDUCTED FROM YOUR PAYCHECK FOR THE CAFETERIA PLAN, AS UNUSED FUNDS CANNOT BE RETURNED. In 2005, the IRS relaxed the “use it or lose it” rules by allowing a grace period for incurring the expense. That grace period has been implemented in the plan. If you have not used all of your balance in a Flexible Spending Account by the end of the plan year, you can continue to claim refunds for that plan year for expenses incurred through the 15th day of the third month following the end of the plan year.

Cafeteria Plan Reimbursement Accounts

There are two types of accounts you may use when participating in the Cafeteria Plan program: one for health care and one for dependent day care. You can open one or the other-or both! You decide how much you want to set aside in an account for the plan year, up to the allowed $2,700 maximum for health and $5,000 for dependent day care. Through payroll deductions, money is conveniently and automatically deposited into a Cafeteria Plan Reimbursement Account each pay period throughout the year-before Federal, State, and Social Security taxes are computed. The minimum contribution necessary to participate is $130.00 per plan year.

PEHP provides benefit cards with medical reimbursement accounts. These cards are the most efficient method of using your medical flexible spending contributions. When you pay co-payments on benefits covered by your PEHP insurance, use the card. The provider will send the claim information to PEHP for payment of their portion. PEHP FLEX personnel will use the claim information to process the charge on the card as a flex claim and reduce your account. If we cannot match the claims data and the card charges, PEHP will contact you and request additional documentation. You do not have to file a claim for charges on the card, but always save your receipts and documentation.

Sometimes you will be able to charge items that are not covered by PEHP insurance on the card, such as other than PEHP insurance, vision exams, and prescription glasses. Since there will be no claims data, PEHP will contact you and request documentation.

If you have an eligible expense for which you did not or could not use the card (non-prescription drugs, band aids, etc. or when your balance is to low to pay the amount from the card), you can submit a claim form to the Public Employees Health Program at 560 East 200 South Suite 100, Salt Lake City, UT 84102-2004. You will then be reimbursed with direct deposit or a check from PEHP with the tax-free money that you have set aside in the account. PEHP will not pay the provider directly except by use of the card.

The Cafeteria Plan Can Save You Money

The Cafeteria Plan saves you money because the money contributed to a Cafeteria Plan Reimbursement Account is not taxed. Cafeteria Plan deductions are taken out of your gross pay before Federal, State, and Social Security taxes are calculated. This means that your taxable income (the income reflected on your annual W-2 form) is lowered. By lowering your taxable income, you'll pay less tax and have more money to spend.

Here's an example of how this works. . .

Susan and Glen both earn $40,000 a year, and pay out of their own pocket $400 for health care and $2,000 for dependent day care incurred during the year. Susan decides to enroll in a Cafeteria Plan Health Care and Dependent Day Care Account. Glen decides not to participate in either Cafeteria Plan account, but claims the dependent childcare credit on his tax return.

	Susan	Glen
Annual pay	$40,000	$40,000
Before-tax Cafeteria Plan contributions (health care and dependent day care expense)	-2,400	-0-
Taxable Income	$37,600	$40,000
Estimated Utah Income Taxes	-1,553	-1,723
Soc Sec Taxes (7.65%)	-2,876	-3,060
Estimated Federal Income	-3,866	-4,226
Take-home pay	$29,305	$30,991

After-tax payment of health care and dependent day care expenses	-0-	-2,400
Federal Tax Credit / Child Care	-0-	400
Remaining annual spendable income	$29,305	$28,991
Increase in spendable income	$ 314	

By using the Cafeteria Plan Reimbursement Accounts, Susan saves $314 in taxes. Glen, on the other hand, is taxed on his full pay. This means that Susan has $314 more in spendable income, even after paying the same $2,400 in expenses that Glen paid. Why pay more taxes than you have to? It makes good sense to use a Cafeteria Plan Reimbursement Account to pay for eligible health care and dependent day care expenses.

This is a conservative example based on the 1999 tax tables. Taxes were calculated for a head-of-household with two exemptions. Of course, the increase in spendable income will vary depending upon the amount that you decide to set aside in a Cafeteria Plan Reimbursement Account and your own individual tax situation.

Immediate Tax Savings

Since The Cafeteria Plan contributions are deducted every pay period, in equal installments throughout the year, your tax savings are immediate--not just when your tax return is filed at the end of the year. Expenses reimbursed with tax-free dollars from a Cafeteria Plan account may not be claimed again as a tax deduction on your annual tax return. In other words, you cannot claim your expenses twice.

YOUR CAFETERIA PLAN HEALTH CARE REIMBURSEMENT ACCOUNT

You can set aside any amount, up to $2,700 a year, in a Cafeteria Plan Health Care Reimbursement Account. This tax-free money is used to reimburse you for eligible health care expenses. To be eligible for reimbursement, you must incur an eligible expense on or after your effective date of coverage during the plan year that you are participating in a Cafeteria Plan Health Care Reimbursement Account. Expenses may be for you or any other person who satisfies the definition of an eligible dependent. Eligible dependents include anyone who qualifies as a dependent for tax purposes under the Internal Revenue Code.

You should only contribute enough money to a Health Care Reimbursement Account to cover the eligible health care expenses that you will incur during the plan year. Since coverage and co-payments vary depending upon which health insurance plan (if any) you or your dependents are enrolled in, consult your plan document for information on coverage limitations AND exclusions. Remember, any money you elect to have deducted into the Cafeteria Plan Reimbursement Account program may be forfeited if you are unable or choose not to claim it within the plan period guidelines.

Eligible Health Care Expenses

In general, any health care expense incurred from legal treatments provided by a licensed health care practitioner, while practicing within the scope of their license and which is not covered by health insurance, is an eligible expense. Additionally, all referrals and prescribed treatments must be made by licensed health care providers practicing within the scope of their license to qualify as an eligible expense. Your medical, dental, and vision insurance premiums are automatically processed through the Cafeteria Plan account.

Here is a partial listing of the type of expenses which may qualify for reimbursement under a Cafeteria Plan Health Care Reimbursement Account:

Medical

- Acupuncture
- Allergy Injections
- Alcohol and Drug Rehabilitation Programs*
- Artificial Eyes and Limbs
- Blood Transfusions
- Charges not considered "Reasonable and Customary"
- Chiropractic Care
- Diabetic Supplies*
- Experimental Procedures
- Hearing Care
- Insulin Treatments
- Insurance Deductibles and Co-payments
- Nursing
- Organ Transplants
- Physical, Speech and Occupational Therapy
- Prescriptions and non-prescription drugs
- Psychotherapy
- Radium Therapy
- Routine Physical Exams
- Sterilization Equipment and Supplies*
- Arches
- Back Supports
- Birth Control Supplies
- Braces and Splints
- Crutches
- Hearing Aides
- Instruction, Training, and Equipment for the Deaf
- Orthopedic Shoes
- Orthotics
- Oxygen and Equipment
- Support Hosiery
- Wheelchairs

Dental

- Bridges

- Cleaning Teeth
- Crowns
- Dental X-rays
- Dentures
- Extracting Teeth
- Fillings
- Fluoride Treatments
- Gum Treatments
- Oral Surgery
- Orthodontics
- TMJ

Vision

- Eye Exams
- Eyeglasses
- Contact Lenses, including lens care supplies
- Laser Eye Surgery
- Instruction, Training, and Equipment for the Blind

Miscellaneous

- Organ Donor Expenses
- Medical equipment and qualified home improvements*
- Maintaining a Mentally Retarded Dependent in a Special Home
- Remedial reading for a Child Suffering from Dyslexia*
- Smoking Cessation Programs*
- Special School Costs for Physically and Mentally Disabled Children with Severe Learning Disabilities*

*Must be prescribed by a Medical Doctor, Doctor of Optometry, Doctor of Podiatry, or Osteopathic Physician for a specific medical condition. A copy of the prescription(s) must accompany expense documentation each time such an item is claimed for Cafeteria Plan reimbursement.

For more information, please consult IRS Publication 502. However, insurance premiums do not qualify for reimbursement from Health Spending Accounts.

Medicare / Medicaid Entitlement

A Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable if the Employee, Spouse, or Dependent Child becomes entitled to coverage under Medicare or Medicaid.

Health Care and Taxes

Unless your out-of-pocket health care expenses exceed 7.5% of your total adjusted gross income, you will not be able to claim them on your Federal tax return. For instance, if your adjusted gross income is $18,000, your health care expenses must exceed $1,350 and then only the expenses exceeding $1,350 can be deducted. Non-prescription drugs and bandages cannot be included in medical expenses on your tax

return, but they are reimbursable from a medical flexible spending account. What can you do about this? Open a Cafeteria Plan Health Care Reimbursement Account! Paying out-of-pocket costs with before-tax dollars gives you immediate tax savings and increases your spendable income.

YOUR CAFETERIA PLAN DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

The amount that you can contribute to a Cafeteria Plan Dependent Day Care Reimbursement Account depends upon whether you are married or single. If you are married, tax laws require that both you and your spouse be employed to use a Dependent Day Care Reimbursement Account (see exception noted below).

- If you are single, you can set aside up to $5,000 a year in a tax-free Dependent Day Care Reimbursement Account.
- If you are married and file a separate tax return, you can put up to $2,500 into a Dependent Day Care Reimbursement Account.
- If you are married and file a joint tax return, the maximum contribution is the lesser of your two incomes, up to a $5,000 limit. For example, suppose you earn $18,000 a year and your spouse earns $4,000, the maximum amount that could be payroll deducted for the Cafeteria Plan Dependent Day Care account is $4,000.
- The minimum contribution is $10.00 per payday.

To be eligible for reimbursement:

- An expense must be incurred on or after your effective date of coverage
- It must occur during the time frame allowed for the plan year in which you are participating in a Cafeteria Plan Dependent Day Care Reimbursement Account
- It must qualify as an eligible expense under the program rules

As in the Health Care Reimbursement Account, you should only contribute enough money to a Dependent Day Care Reimbursement Account to cover the eligible dependent day care expenses that you will incur during the plan year. Remember, any money you elect to have deducted into the Cafeteria Plan Reimbursement Account Program may be forfeited if you are unable or choose not to claim it within the plan period guidelines.

Eligible Dependent Day Care Expenses

The dependent or childcare costs that you incur, in order for you and your spouse (if applicable) to work, qualify as eligible expenses. In addition, if your spouse is disabled or attends school and is not able to care for your eligible dependents, costs incurred to care for your eligible dependents may also be covered. Eligible dependents include anyone who qualifies as a dependent for tax purposes under the Internal Revenue Code. You may not use a Dependent Day Care Reimbursement Account to pay for babysitting expenses for a social event or for the cost of sending your child to an overnight camp.

Also excluded is any expense that is excluded by federal regulations including but not limited to food, clothing, or educational services unless these services are minimal or insignificant and inseparable from the portion of the expense that is for care,

or for the individual's well being and protection. Educational services where the primary purpose is education, not care, include, but are not limited to, elementary and secondary schools, summer schools, continuing education classes, etc.

Some examples of eligible expenses are:
- A qualified day care center, nursery school, babysitter, or nurse.
- A maid or cook, if part of their job is to care for a person who qualifies for dependent day care.
- A relative who provides dependent day care, if the relative is not your dependent for income tax purposes or your child or stepchild under age 19.

To qualify for reimbursement under this program, your dependent children must be under age 13.
- Dependents that are age 13 or older must be totally disabled and spend at least eight hours each day in your home.
- If dependent day care services are provided by a day care facility that cares for more than six children at once, it must be a state licensed day care center.
- You must furnish the name, address and taxpayers' identification number (Social Security number) of each day care facility or private individual that provides care on each Cafeteria Plan claim submitted.(1)

Dependent Day Care and Taxes

Eligible dependent day care expenses can save you taxes in two different ways: you may be entitled to a tax credit on your individual tax return, and you may participate in a Cafeteria Plan Dependent Day Care Reimbursement Account.

The maximum Federal tax credit available for one dependent is $2,400 and $4,800 for two or more dependents. (Please note: the available tax credit and the additional savings realized on Social Security and State taxes, by participation in a Cafeteria Plan Dependent Day Care Reimbursement Account may result in greater tax savings than the Federal tax credit. Generally speaking, families earning around $25,000 or more are better off using a (Dependent Day Care Reimbursement Account). Participation in a Dependent Day Care Reimbursement Account would also benefit certain low-income families (i.e., families who have adjusted gross incomes which result in no Federal income tax liability, do not benefit from a tax credit, but would save on Social Security taxes).

It is important to note that new tax laws, effective January 1, 1989, reduce dollar for dollar the Federal tax credit available to you when you participate in a Dependent Day Care Reimbursement Account. For example: if your tax credit is $4,800 and you use a Dependent Day Care Reimbursement Account to pay $4,000 in dependent day care expenses, you can only claim up to an $800 credit on your Federal tax return. Expenses claimed through a Cafeteria Plan account cannot be claimed again as a yearend tax credit; however, that portion of eligible expenses not claimed through The Cafeteria Plan may be eligible for a yearend tax credit.

Before making your final decision about participation in a Cafeteria Plan Dependent Day Care Reimbursement Account, please consult a tax professional.

HOW THE CAFETERIA PLAN AFFECTS YOUR OTHER BENEFITS

Many of the benefits that you receive are based upon your salary. Included in this category are disability coverage, retirement, social security, and deferred compensation. Of these, the only benefits that could possibly be affected by your participation in The Cafeteria Plan are social security and deferred compensation.

Social Security

Since The Cafeteria Plan contributions are deducted on a before-tax basis, they are not included in your F.I.C.A. taxable wages. As a result, your Social Security benefit at retirement may be reduced, but only slightly. With the changes in Social Security benefits and taxes, and with the increasing age at which employees can receive Social Security retirement benefits, the calculation of the actual impact may be different for each individual. However, the savings in taxes more than make up for the small loss of Social Security benefits at retirement. If you want to know the actual impact on your benefits, contact the Social Security Administration.

Deferred Compensation

Additional tax savings may be realized if you choose to participate in both The Cafeteria Plan and one of the Deferred Compensation Plans (DCP), either a 401(k),457or 403(b). Income, for DCP purposes, means your income remaining after all tax-free and tax-deferred deductions have been taken. Since The Cafeteria Plan contributions are tax-free, the maximum DCP contribution that you are allowed to make may be lower than anticipated depending on the amount of The Cafeteria Plan contribution. Please call the Public Employees Health Program (801) 366-7503 if you have any questions regarding the Cafeteria Plan program affect on DCP. However, remember that dollars directed to 401(k), 457 or 403(b) plans also reduce your State and Federal tax withholdings (but not FICA withholdings).

CAFETERIA PLAN ELIGIBILITY AND ENROLLMENT

All medical insurance eligible employees may enroll and participate in the Cafeteria Plan program. Others may be eligible. If you are unsure whether you are eligible to participate or not, check with your payroll person.

The annual open enrollment period will be held in the month May for the following plan year. To participate in an upcoming year, you must enroll on line at www.pehp.org or return a completed enrollment form to the Public Employees Health Program, 560 East 200 South, Suite 100, Salt Lake City, UT 84102-2004 by the end of the enrollment period. You must re-enroll each year that you wish to participate in the Cafeteria Plan program. This gives you the opportunity to evaluate your needs for the new period and possibly change your elected deduction amounts. Enrollment forms are available online at www.pehp.org.

New employees may enroll within the first 60 days of their employment by providing the Public Employees Health Program with a completed enrollment form and

verification of hire date.

Employees who have a change in family status (i.e., marriage, divorce, birth of a child, etc.) may enroll within 60 days of the event. Proper documentation (marriage license, birth certificate, divorce decree, etc.) and a completed Cafeteria Plan application must be received by the Public Employees Health Program within 60 days of the change in family status.

It is then the employee's responsibility to monitor their own paycheck stubs to see that the intended change occurs. If the expected change does not take place, the employee must contact their payroll department or Public Employees Health Program (801) 366-7503 immediately so that adjustments can be made.

EFFECTIVE DATE OF COVERAGE

When you enroll in The Cafeteria Plan during the November open enrollment period, your coverage becomes effective on January 1st, the start of the next plan year. For new employees who enroll within the first 60 days of their employment, coverage becomes effective on their hire date. If an employee, following a change in family status (i.e. marriage, divorce, birth of a child, etc.):

- enrolls in a Cafeteria Plan account, coverage is effective on the date that the family status change occurred.
- chooses to increase contributions to an existing Cafeteria Plan account; the original effective date of coverage for the current plan year applies to the increased amount.
- wishes to decrease or stop payroll deductions to an existing Cafeteria Plan account, there is no change to the effective date of coverage.

You may submit claims for eligible expenses incurred on or after the effective date of coverage for the plan period in which you are enrolled.

CHANGING YOUR CAFETERIA PLAN DEDUCTIONS

The payroll deduction that you choose for The Cafeteria Plan may not be changed during the course of a year unless you have a change in status, change in your family's status (i.e., marriage, divorce, birth of a child, etc.) and/or change in your employment status. Within 60 days of the change in status you are required to furnish the Public Employees Health Program 560 East 200 South, Suite 100, Salt Lake City, UT 84102-2004 with proper documentation (marriage license, birth certificate, divorce decree, etc.) and complete a new Cafeteria Plan application. Payroll deductions may be started, stopped, increased or decreased if one of the above status changes occur. However, the change in the new election must be consistent with the status change.

In addition, money cannot be transferred between Cafeteria Plan accounts. There are strict government rules, which state that the money contributed to each account must remain completely separate and dedicated to its original elected purpose.

CAFETERIA PLAN CLAIM AND REIMBURSEMENT PROCESS

The Cafeteria Plan covers eligible health care and dependent day care expenses that are incurred for the plan year that you are enrolled. This means that treatment and/or services must be provided on or after your effective date of coverage and during the time allowed for the plan year that you are a participant. The date that an expense was paid has no bearing on whether or not it is eligible under the program.

Whenever you have verification of an eligible expense that was not paid with the card, you must complete a Cafeteria Plan claim to receive reimbursement. Claim forms may be obtained from your department payroll clerk. Claims will be processed and the eligible amount reimbursed directly to you by PEHP. Cafeteria Plan reimbursements will not be considered part of your taxable income for the year.

Claim Submission Deadlines

PEHP processes paper claims with in two days of receipt. Direct deposit and check payments will be made at least twice a week. You have 90 days following the end of the plan year to submit claims to the Public Employees Health Program for reimbursement of health care and/or dependent day care expenses incurred for the previous plan year.

Claim Documentation

When submitting Cafeteria Plan paper claims, each expense that you claim must be supported by appropriate documentation. Appropriate documentation includes good quality copies of original: receipts, statements, OR any other document that shows the name of the provider, the service date, the type of service, and the amount of your total out-of-pocket expense.

It is recommended that you keep your own original receipts of service and billings, regardless of whether the card was used or you paid by other means. A personal record should be kept of exactly what you have submitted. This is especially important because the Public Employees Health Program is unable to provide you with copies of The Cafeteria Plan claims and claims documentation.

If the required information is not on the claim, the claim may be rejected and sent back to you. The minimum required data includes: social security number, employee name and address information, date(s) of service received, type of service received, service provider, and amount of the claim. In addition, the claim MUST be signed, and if you are submitting a dependent day care claim, the provider's tax ID number must be provided.

Health Care Claims

If an expense is not covered by a medical or dental plan, itemized statements or receipts from the health care provider are acceptable as documentation. In addition, some health care expenses may require that a written prescription be furnished by your physician or health care provider.

Medical claims are prepaid up to the elected annual deduction amount, even though the reimbursement may be more than you have had deducted at that time. If you should terminate before the end of the plan year, and have been reimbursed more than you have had deducted through the Cafeteria Plan program, you may have the additional amount deducted from your final paycheck.

Some form of documentation must accompany each item claimed, including claims for ongoing service situations. Due to the unique nature of orthodontia expenses, the following special documentation requirements have been established for paper claims:

- The first orthodontia claim submitted must include a copy of the written agreement between you and the orthodontist, indicating the total estimated charges and the period of treatment.
- All claims submitted must include copies of receipts from the orthodontist as evidence of payment.

When using the card, documentation in addition to the claims data from PEHP may be needed for dental claims. We will contact you if we need the documentation.

Dependent Day Care Claims

Acceptable documentation for dependent day care expenses are copies of provider issued receipts or statements. PLEASE NOTE: To comply with new Federal tax law, the provider's name, address and taxpayer identification number (Social Security number) must be listed on each dependent day care claim. This information should be noted in the "NAME OF PROVIDER AND TAX ID#" section of the Cafeteria Plan Reimbursement claim form.

While the card is not available for dependent day care, we do have a process for automatic reimbursement. The participant with on going, month to month expenses can submit a request form with provider data at the first of the year. When accepted, PEHP will reimburse the payroll contributions by direct deposit at the next payment process after receipt of the contributions from the employer. No other documentation or requests need to be provided until the end of the year. At the end of the year, the participant will provide PEHP with a statement or receipts from the provider showing the total charges for the year. The participant must sign up for direct deposit to participate in automatic reimbursement.

Denied Cafeteria Plan Claims

Denied Cafeteria Plan claims may be appealed. Appeals must be received in writing, along with any supporting documentation, by the PEHP within 60 days of the denial notification. The PEHP will then respond within 60 days of receipt of your appeal.

Participants will be informed of all claims denied by the PEHP as being ineligible for reimbursement. Participants may not necessarily be informed if reimbursement is not forthcoming due to the amount claimed being more than the amount chosen as the elected deduction amount, for dependant day care.

With the Dependent Day Care Account, participants are only allowed reimbursement for the amount they have contributed.

With the Health Care Reimbursement Account, participants can only be reimbursed for the amount they have elected to contribute during the plan year.

Name and Address Changes

Employees are responsible for informing their own payroll/human resource department whenever there is a name and/or address change. Employees should then

monitor their paychecks to verify that the name and/or address change takes place within the payroll system. Employees must include the correct home address on the claim. Failure to do so may result in delays in receiving Cafeteria Plan reimbursements. This can be avoided by signing up for direct deposit.

Duplicate Reimbursement/Overpayment

If reimbursement from Cafeteria Plan and any other source exceeds 100% of a health care or dependent day care expense, the Public Employees Health Program will either require you to refund the excess amount or will adjust future claim payment(s). In the event that your Cafeteria Plan reimbursements exceed the total amount that you have contributed for the year, you will be required to refund the difference within 15 days after notification by the Public Employees Health Program.

Termination of Employment/Employment Status Change

If your employment terminates, you retire, or you go from an eligible to an ineligible status during the year, you may either pre-pay the remaining obligation under the Salary Reduction Agreement, chose to continue your cafeteria plan benefit by filing out a COBRA enrollment form, or revoke all existing benefit elections and terminate your entitlement to the reimbursement of expenses incurred during the Plan Year.

A Participant who separates from service may elect to pre-pay the remaining obligation under the current Salary Reduction Agreement. The Participant may then apply for reimbursement throughout the end of that Plan Year.

If a Participant who separates from service elects COBRA, they will continue to make contributions to the Plan to provide for the funding of Benefits for the remainder of that Plan Year. If the individual (Qualified Beneficiary (QB)) who elects COBRA fails to timely make any required contributions, that QB shall not be entitled to reimbursements for the portion of the Plan Year for which contributions were not made. (Refer to COBRA requirements under Article 8 of the Plan Document)

In the event of your death, reimbursement for eligible expenses may be filed by your dependents (if any) until your accumulated contributions have been exhausted. In no event, however, will reimbursement be made for claims received after the applicable Cafeteria Plan claims submission deadlines.

A Participant, who separates from service and then returns to service as an Eligible Employee within 30 days, may have the previous election automatically reinstated for the remainder of that Plan Year. If the former Participant returns to service as an Eligible Employee after 30 days, the Employee may make a new election or resume the previous election for the remainder of that Plan Year.

BEFORE YOU DECIDE

Take some time to think about the health care needs of your family. Review last year's medical, dental, and vision expenses and those from the year before. Then, estimate your out-of-pocket expenses for the upcoming year considering what your medical and/or dental plan(s) cover and what portion you must pay.

If you pay for dependent day care, estimate the amount you expect to pay over the next year. Consider any changes that will occur in dependent day care costs and in

the number of eligible dependents you may claim. Remember to take into account such predictable events as family vacations, children entering school, etc.
Cafeteria Plan Reimbursement Accounts should only be used for expenses that you can accurately predict. Ask yourself these questions. . .

Does anyone in my family wear contacts, glasses, or a hearing aid?
Do my children need orthodontia? Does my doctor want me to quit smoking?
Do I have any small medical bills, not covered by insurance, that chip away at my hard-earned paycheck?
Do I pay for the care of an incapacitated spouse or dependent parent?
Do I have young children who need day care so I can work?
Do I pay a housekeeper to care for my child part of the day?

If you answer YES to any of the above questions, a Cafeteria Plan Reimbursement Account may be right for you. Why not pay your predictable health care and dependent day care expenses with tax-free money?

ABOUT THIS DOCUMENT

This document summarizes the major features of the 125 Cafeteria Plan (Cafeteria Plan). It is recommended that you attempt to refer to the most recent printing of this material occasionally during the plan year. Every effort has been made to make sure this information is clear, easy to understand and accurate. The official plan document contains complete plan provisions and is available for inspection, upon request, through your Employer, or at the Public Employee Health Program Office. In case of any discrepancy between this document and the official plan document, the official plan document will take precedence.

FOR ADDITIONAL INFORMATION

For further clarification of the concepts and rules contained within this document, or if you are experiencing any problem with your Cafeteria Plan accounts, please contact the Public Employees Health Program, FLEX Plan Administration, 560 East 200 South, Suite 110, Salt Lake City, Utah 84102-2004 at (801) 366-7503 or (800) 753-7751.

Cafeteria Plan Administrative Agreement

COMES NOW the GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT ("Employer"), a political subdivision of the State of Utah, and the Public Employees Health Program ("PEHP") a division of the Utah Retirement Office, an independent agency of the State of Utah (Employer and PEHP referred to jointly as the "Parties.") and hereby enter into this Cafeteria Plan Administrative Agreement ("Agreement").

Recitals

WHEREAS, Employer has adopted a cafeteria plan to section 125 of the Internal Revenue Code (the "Plan") for the benefit of its employees; and

WHEREAS, PEHP has agreed to serve as the Plan Administrator of the Plan to the extent described in this Agreement; and

WHEREAS, the Parties desire to set forth the rights and obligations of each in relationship to the Plan and;

WHEREAS, PEHP has contracted for the use of an association (MasterCard©, Visa©, Discover©, and/or American Express©) branded debit card ("Card"), for use with employee benefit accounts included in the Plan and;

WHEREAS, Employer wishes PEHP to utilize the Card to assist in the electronic adjudication of such accounts.

NOW, THEREFORE, based on the mutual covenants and promises contained herein, the receipt and sufficiency of which are acknowledged, the Parties hereby agree as follows:

Section I - Definitions

A. Card Transaction means when the Card is presented for payment of goods and/or services.
B. Plan Participants mean employees and their authorized dependents living in the United States and participating in the Plan of the Employer whereby the Card is offered to its employees.

Section II - Term and Termination

A. Effective Date. The effective date of this Agreement shall be May 1, 2019.

B. Term. The term of this Agreement shall be one year and will automatically renew in one year increments if there is no termination by either Party.

C. Termination. This Agreement may be terminated by either Party upon 90 (ninety) days written notice to the other Party.

Section III - Employer Responsibilities

A. The Employer. Employer shall carry out its duties as set forth in the plan documents attached as Exhibit A and Exhibit C hereto and incorporated herein by this reference. Notwithstanding any provision of the plan documents, Employer shall be solely responsible for all nondiscrimination testing or other plan qualification requirements which are based on information under the control of Employer. The Employer represents and warrants that the Plan Participants are subject to the cardholder agreement, including the safe guarding of the card at all times and the timely reporting of fraudulent activities to the Card provider and/or PEHP within 72 hours of becoming aware of the fraudulent activities. The Employer will notify PEHP of all terminating employees and make every reasonable effort to retrieve the Card from terminating Plan Participants.

B. Plan Funding. Participants' accounts shall be funded through payroll deductions and/or employer contributions. Employer shall immediately forward such funding to PEHP as directed by PEHP. At the beginning of each Plan Year, Employer shall deposit with PEHP a deposit in an amount equal to one-sixth of the total amount to be contributed to the Plan for Health Care accounts for that Plan Year through employee payroll deductions. In the event the deposit falls below 25 percent of its original amount, upon written notice from PEHP the employer shall immediately contribute to the deposit the amount necessary to return the deposit to its original amount. The Employer accepts responsibility to PEHP for any and all charges made on the Card by participants and/or their dependents. If PEHP and Employer agree, the deposit can be coordinated with the Employer's medical risk pool reserves.

C. Reimbursements for Qualified Expenses. Upon receipt from the Employer or Participant of a request for reimbursement, PEHP shall adjudicate such request as required and, if eligible, pay those reimbursements to the Participant from the accumulated funding and Employer deposit. In accordance with the plan documents and governing regulations, a Participant who fails to use all of the money in the Participant's Flexible Spending Account for a Plan Year forfeits the remaining money. All forfeited money at the end of a Plan Year belongs to the Employer.

D. Annual Reconciliation. At the end of each Plan Year, the financial status of the Plan shall be calculated by aggregating the balance of all Flexible Spending Accounts (FSA) after the payout period for that Plan Year.

E. Performance of Duties. Employer shall assure that the requirements set forth in paragraph II B are performed in accordance with this Agreement and agrees that the indemnification contained in paragraph III F applies to the requirements of this paragraph.

F. Indemnification. Employer shall indemnify and hold PEHP harmless from and against any liability, fines, fees, costs (including court costs and reasonable attorneys' fees), judgements,

settlements or penalties arising out of Employer's acts or omissions relating to its obligations under the Plan.

G. Adoption of Plan Document. Employer acknowledges that it has taken all necessary action to adopt the plan documents attached as Exhibit A and Exhibit C. Employer further acknowledges that it has had the opportunity to have the plan documents reviewed by tax, legal, or business representatives, and that it is not relied upon PEHP or PEHP's employees, agents, attorneys, or accountants to provide any tax, legal, or business advice in adopting the plan documents.

H. Fees.

1) The Employer agrees to the fees per the schedule of fees attached as Exhibit B. Fees shall be paid to PEHP on a pay period basis or charged to the employer's medical risk pool. If the employer elects to have the participants pay the fees, they will be deducted from the participants' FSA or Health Savings Account (HSA) accounts.

2) There shall be no fees for Participants participating only in the Premium Reimbursement Program.

I. Information. Employer agrees to provide the following information to PEHP:

1) Legible copies of all salary reduction agreements and contribution adjustment forms the Employer receives.
2) All new effective dates of employment and termination of Participants, and any changes in Participant mailing addresses.
3) Information for preparing reports including the following for completing the form 5500 when required:
   total number of employees
   total number of employees eligible to participate in the plan
   total number of employees participating in the plan
   total cost of the plan

J. Additional Employer Duties. Employer shall perform the following:

1) Implement the Cafeteria Plan document effective on or before the effective date of this Agreement.
2) Implement the salary reduction agreement for each Participant though payroll processing in accordance with the plan.
3) Transfer to PEHP the amount of payroll deductions for Flexible Spending Accounts and other funding.
4) Provide PEHP with an electronic file with records for each account for each participant in the format prescribed by PEHP.
5) Provide terminating Participant with accurate information regarding their options relating to their account(s).
6) All other duties as identified in the plan documents.

Section VI - PEHP Responsibilities

A. Plan Administrator. PEHP shall act as the Plan Administrator of the plans and carry out the duties required of the Plan Administrator as set forth in the plan documents to the extent described in this Agreement.

B. PEHP Duties. PEHP shall perform the following:

1) Provide masters for all forms required (salary reduction agreements, claim forms, contribution adjustment forms, direct deposit forms, automatic reimbursement forms, and others).
2) Meet with employee groups to explain the plans and answer questions.
3) Maintain a file of all salary reduction agreements and contribution adjustment forms received from the employer and employees.
4) Have the cardholder agreement issued with the Card and/or available for the Plan Participants.
5) Work with the card provider in the recovery of Card Transaction amounts reported as fraudulent transaction activity by Plan Participants and/or the Employer, provided that the Plan Participants comply with the terms outlined in the cardholder agreement for the timely reporting of such activity.
6) Timely deactivate the Card for terminating Plan Participants.
7) Receive, review, process, and adjudicate paper and card charge claims.
8) Make reimbursement to Participant for claims or portions of claims that meet the plan requirements and IRS regulations. Reimbursement for adjudicated card charges will be the clearing of the charge and the reduction of the participant's account balance.
9) Notify Participants promptly of any claim amounts denied for any reason other than insufficient funds in the employee's spending accounts.
10) Notify all Participants of the balances in each of their spending accounts as of 60 Days prior to the end of the plan year, including amounts that will be forfeited if not claimed according to the plan.
11) Prepare a final report of balances of each type of spending account, forfeitures, deficiencies, and reserves after the plan year is closed.
12) Prepare form 5500, when required, for filing with the Internal Revenue Service, sign the form as Plan Administrator, and forward the form to the Employer for signing and filing.
13) Maintain an appropriate level of confidentiality on all information received.
14) All other duties as identified in the plan documents.

C. Audits. PEHP shall perform internal audits of the Plan in accordance with its internal policies and procedures, and provide Employer with summaries of the audits when requested.

D. Indemnification. PEHP shall indemnify and hold Employer harmless from and against any liability, fines, fees, costs (including court costs and reasonable attorneys fees), judgements, settlements or penalties arising out of PEHP's acts or omissions in performing its duties and obligations under this Agreement and the plan documents as incorporated herein.

Section V - Miscellaneous

A. Use of Defined Terms. All capitalized terms that are not defined in this Agreement shall have the same meaning as set forth in plan documents attached as Exhibit A and Exhibit C.

B. Governmental Plan. The Parties agree that the Plan is a "governmental plan" as defined by the Employee Retirement Income Security Act of 1974 ("ERISA"), and is thereby exempt from ERISA.

C. Notices. Any written notices required by this Agreement or the plan documents shall be delivered by personal delivery, first-class U.S. mail, registered mail, certified mail, facsimile, or recognized over-night courier service, as follows:

If to PEHP: Attention: 125 Plan Administrator
560 East 200 South
Salt Lake City, UT 84102

If to Employer: GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT
2001 South State St N3-606
SALT LAKE CITY, UT 84190

D. Modifications. This Agreement may not be modified, altered, or amended in any manner unless such modification, alteration, or amendment shall be reduced to writing and executed by all parties to this Agreement.

E. Assignment. Neither Party may assign this Agreement without the written consent of the other Party.

F. Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

G. Paragraph and Other Headings. Paragraph and other headings of this Agreement are for reference purposes only and shall not be deemed to alter the meaning or intent of the language of this Agreement exclusive of such headings.

H. Entire Agreement. This Agreement with referenced documents constitutes the entire Agreement by and between the parties hereto with respect to the subject matter hereon and supersedes all prior negotiations between the parties and any other statement whether oral or written and shall not be deemed a part of this Agreement unless specifically incorporated herein and by reference.

I. Severability. Each provision of this Agreement shall be interpreted in such manner as to be effective and valid under applicable law, but if any provision of this Agreement is deemed to be prohibitive by or invalid under applicable law, such provisions shall be ineffective only to the extent of such prohibition or invalidity, without invalidating the remainder of such provision or the remaining provisions of this Agreement.

J. Governing Law. This Agreement and documents to be pursuant hereto shall be construed in accordance with and governed by the laws of the State of Utah.

K. Construction. This Agreement shall be construed as whole and in accordance with its fair meaning without regard to any presumption or other rule requiring construction against the party preparing this Agreement or any part hereof.

L. No Waiver. The waiver by one part of the performance of any covenant or condition hereunder shall not invalidate this Agreement, nor shall it be considered to be a waiver by such party of any covenant or condition hereunder. The waiver by either party or both parties of the time for performing any act hereunder shall not be deemed a waiver of any other act or an identical act required to be performed at a later time. The exercise of any remedy provided by law and the provisions of this Agreement before any remedy, shall not exclude other remedies unless they are expressly excluded.

M. Authority. The person signing on behalf of the Parties represent that they have the authority to sign this document on behalf of the Parties and bind the Parties to the obligations contained herein.

PEHP	GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT
By:_____	By:_____
Date:_____	Date:_____

EXHIBIT B

Public Employees Health Program

Flexible Spending /Limited FSA Account Fees

Fees for flexible spending account (FSA) administration are set to encourage efficiencies and minimize the costs. With PEHP and employer approval, the fees can be conveniently charged to the medical risk pool.

Base fee: $2.50 per participant per month, whether the participant has a health FSA, a dependent day care FSA, or both. This includes the benefit card for health FSA, claim adjudication, reports, customer service, and appeals processing.

Additional fees:

$0.50 per participant per month is added if the employer carves out the pharmacy benefit and does not provide PEHP with the pharmacy claims data from the other provider(s).

$0.25 per participant per month is added if the employer does not offer PEHP dental and does not provide PEHP with the dental claims data from the other provider(s).

Other fees will be charged at cost for non-standard service requests, as additional card or cards for dependents away from home.

Initial deposit:

One sixth of the annual health FSA contributions will be necessary to fund card charges and claim reimbursements in excess of year-to-date contributions. Additional funds may be requested by PEHP if needed. With acceptance from PEHP and the employer, this may be coordinated and included with the medical reserve deposit.

There are no set up fees. There are no charges for plan documents. There are no fees for reports. There are no fees for the premium only plan. There is no minimum number of participants per employer.

I agree to this schedule of fees. _____ Date _____

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

INSURANCE PREMIUM PAYMENT PLAN
SUMMARY PLAN DOCUMENT

The Insurance Premium Payment portion of the Cafeteria Plan allows Employees to participate in the office's medical, dental, accident and other benefit programs allowable under the Code, and to pay the required portion of the eligible premiums with pre-tax dollars (i.e. salary which is allowed to be not subject to taxes).

This portion of the Cafeteria Plan will become effective January 1st for all eligible Employees. Unless an employee elects not to participate by December 15th, any eligible insurance premiums under the office's accident, medical, and dental benefit programs, which are currently payable by the Employee will be paid by the Employer and the Employee's salary will be adjusted downward to reflect the premiums paid.

By reducing your salary (gross), all Federal and State withholdings are reduced, including Social Security (FICA) payments. Such reductions will not lower the retirement contributions made on your behalf.

All Employees enrolled in an eligible insurance plan are automatically enrolled in this plan unless an "Election Not To Participate" form is completed and returned to the payroll department by December 15th.

A copy of the Plan Document is available upon request.

If you have any questions about participating in or excepting yourself from the Insurance Premium Payment portion of the 125 Cafeteria Plan, please contact the payroll department.

INSURANCE PREMIUM PAYMENT PLAN

ARTICLE I PURPOSE OF PLAN

1.01 Purpose. The purpose of the Insurance Premium Payment Plan (the "Plan") is to permit Employees of the Employer to participate in the office's medical, dental, accident, and other insurance benefit programs allowable under the Code, and to pay the required portion of the eligible premiums, on a basis which is intended to provide to them significant income tax advantages, as permitted by Section 125 of the Internal Revenue Code, (IRC) as amended.

Under the Plan, unless a Participant elects to the contrary, any monthly insurance premiums under the office's medical and dental benefit program, which are currently payable by the Participant will be paid directly by the office. In return for payment of the premiums by the office, the Participant agrees to have his or her salary adjusted downward to reflect the amount of the premiums so paid. The Plan may provide significant tax advantages to the Participants in that the required premiums will be paid with funds, which will not be subject to federal income tax, and the corresponding amount of the salary reductions of Participants should not be includable in their gross income for federal income tax purposes.

The tax advantage, which the Plan is intended to provide, is subject to government rulings, regulations and application of the tax laws by the Internal Revenue Service. Although it may anticipate certain tax consequences as being likely, the Employer does not promise or represent to any person that any particular tax consequence will result from participation in this Plan.

The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code of 1986, as amended, and shall be construed and interpreted consistent with the requirements of that Section.

ARTICLE II DEFINITIONS

The following words and phrases have the following meanings, unless a different meaning is plainly required by the text:

2.01 ***Code.*** "Code" means the Internal Revenue Code of 1986, as amended.

2.02 ***Effective Date***. "Effective Date" means May 1, 2019.

2.03 ***Employee.*** "Employee" means an Employee of the Employer who meets the eligibility requirements of the Employer's accident, medical, and dental benefit programs.

2.04 ***Employer.*** "Employer" means **GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT.**

2.05 ***Participant.*** "Participant" means an Employee who has elected to participate in the Plan.

2.06 ***Plan.*** "Plan" means the Insurance Premium Payment Plan.

2.07 ***Plan Year.*** "Plan Year" means the twelve consecutive month period beginning January 1st and ending December 31st . If the effective date is other than January 1st the plan year is from the effective date to December 31st.

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.01 ***Eligibility.*** Each Employee who elects coverage under the Employer's accident, medical and

dental benefit programs is eligible to participate in the Plan.

3.02 ***Participation.*** Unless otherwise elected under section 3.03, each Employee shall be a Participant in the Plan for a Plan Year.

3.03 ***Election not to Participate.*** An Employee who is eligible to participate in the Plan may elect not to participate by completing and filing an appropriate election form before the day the Employee's coverage under the Employer's accident, medical, or dental benefit begin and within the election period established by the Employer.

3.04 ***Changes in Participation Status.***

(a) An Employee's participation status at the end of a Plan Year shall be automatically continued for the subsequent Plan year unless the employee completes and files an appropriate election form under section 3.03 during the election period established by the Employer.

(b) A Participant may revoke or amend participation in the Plan during a Plan Year only on account of and consistent with a status change, a change in family status, and/or employment status change. A status includes: marriage, divorce, death of a spouse or child, birth or adoption of a child, or an employment change of the spouse which affects the spouse's eligibility for benefits under another group, medical or dental plan, or such other event allowed under applicable law or regulation. A revocation or amendment or participation must be made within sixty (60) days after the change in family status and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made. The change made must be consistent with the status change, family, or employment status change.

3.05 ***HIPAA/Special Enrollment***. In the case of a Benefit Plan that provides health coverage, and not for Qualified Health Care Expense accounts, a Participant may revoke participation in a Benefit Plan and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), whether or not the change is permitted under any other section of this Plan.

For Individuals losing other Coverage:

(1) An Employee may revoke participation in a Benefit Plan and make a new election if the Employee is eligible, but not enrolled, for coverage under the terms of the Benefit Plan (or a Spouse or Dependent Child of such an Employee if the Spouse or Dependent Child is eligible, but not enrolled, for coverage); and

  (1) The Employee, Spouse or Dependent Child was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Employee.

  (2) The Employee's Spouse's or Dependent Child's coverage under a group health plan or health insurance was:

    (1) Under a COBRA continuation provision and the coverage under such provision was exhausted; or

    (2) Not under a COBRA continuation provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or the employer contributions towards such coverage were terminated.

(2) In this case, a revocation or amendment of participation must be made within 30 days

after the date of exhaustion of coverage described in subparagraph f., 1.,(a),(1) or the termination of coverage or employer contribution described in subparagraph f.,1., (a),(3) and will be effective for the balance of the Plan Year in which the election is made, beginning on the first day of the month following the month in which the election is made.

For Acquisitions of a Spouse or Dependent Child:

(1) A Participant may revoke participation in a Benefit Plan and make a new election if the individual is a Participant under the Benefit Plan (or has met any waiting period applicable to becoming a Participant under the Plan and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period), and

(2) A person becomes a Spouse or a Dependent Child of the Participant through marriage, birth, or adoption or placement for adoption, and

(3) The Participant elects to enroll himself or herself, the Spouse, and/or the Participant's Dependent Child or Children in the Plan, to the extent that the Spouse or Dependent Children are otherwise eligible for coverage.

(4) In this case, a revocation or amendment or participation must be make within 30 days after the date dependent coverage is made available or the date of the marriage, birth, or adoption or placement for adoption and will be effective for the balance of the Plan year in which the election is made, as follows:

  (1) in the case of marriage, not later than the first day of the first month beginning after the date the completed request for enrollment is received;

  (1) in the case of a Dependent Child's birth, as of the date of such birth; or

  (2) in the case of a Dependent Child's adoption or placement for adoption, the date of such adoption or placement for adoption.

A Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

(1) if a judgment, decree, or order (collectively, "Order") results from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order defined in Section 609 of ERISA) that requires accident or health coverage for an Employee's Dependent Child, and

(2) the Employee changes his or her election to provide coverage for the Dependent Child if the Order requires coverage under the Employee's plan; or

(3) the Employee changes he or her election to revoke coverage for the Dependent Child if the Order requires the former spouse to provide coverage.

3.06 ***Medicare / Medicaid Entitlement***. A Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

(a) if the Employee, Spouse, or Dependent Child becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of the benefits under Section 1928 of the Social Security Act (the program for the distribution of

pediatric vaccines); and

(b) the Employee changes his or her election to revoke coverage for that Employee, Spouse or Dependent Child under the Plan.

3.07 ***Termination of Participation.*** Participation during a Plan Year terminates on the date a Participant ceases to be an Employee or fails to meet the eligibility requirements of section 3.01 or revokes participation under section 3.04, or the date the Plan is terminated.

ARTICLE IV BENEFITS AND SALARY REDUCTION

4.01 ***Benefits.*** The Employer shall pay the entire cost or premium of the medical, dental, and accident insurance benefits selected by a Participant.

4.02 ***Salary Reduction.*** As a Participant in the Plan, each Employee agrees to reduce his or her salary or wage each month by the amount of the Participant's portion of the monthly premium paid by the Employer in section 4.01. The premium amounts paid by the Employer will be adjusted to reflect changes in the cost or insurance premiums of the medical, dental and accident insurance and other benefits. Such changes will automatically be reflected in the amount of a Participant's salary reduction.

ARTICLE V ADMINISTRATION

5.01 ***Employer Powers and Duties.*** The Employer shall manage and administer the Plan. The Employer shall interpret the Plan and decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Employer with respect to any matter under the Plan shall be conclusive and binding on all persons. The Employer may:

(a) Require any person to furnish such information as it may request for the purpose of the proper administration of the Plan and as a condition to receiving any benefits under the Plan.
(b) Make and enforce administrative rules and prescribe the use of such forms as it considers necessary for the efficient administration of the Plan.
(c) Decide questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan.
(d) Determine the amount of benefits which are payable to any person in accordance with the provisions of the Plan; and provide full and fair review to any Participant whose claim for benefits has been denied in whole or in part.
(e) Delegate to appropriate third parties the Employer's powers and duties under the Plan.

5.02 ***Expenses.*** All expenses incurred prior to the termination of the Plan that arise in connection with the administration of the Plan, shall be paid by the Employer.

5.03 ***Additional Operating Rules.***

(a) The amount of all costs of insurance premiums paid by the Employer pursuant to a Participant's salary reduction election will not be subject to federal or state income tax

withholding or Social Security (FICA and FUTA) tax withholding. Salary reduction amounts under this Plan shall not reduce salary or wage amounts for purposes of any other Employer sponsored Employee benefit program unless the terms of the program provides otherwise.

(b) In no event may the amount of salary reduction under this Plan in any month or pay period exceed the amount of a Participant's net salary for such month or pay period. Further, no salary reduction shall be made when the amount of the salary reduction under this Plan in any month or pay period exceeds the amount of a Participant's net salary for such month or pay period.

(c) In the event the Participant is on an unpaid leave of absence or other circumstances where the Participant continues to be a member of the accident, medical and dental benefit programs offered by the Employer and the Participant does not receive a salary sufficient to pay the insurance premium, it is the responsibility of the Participant to remit to the Employer funds as to cover the Participant's share of insurance premiums. Such payments shall be made monthly.

ARTICLE VI CLAIMS PROCEDURE

6.01 ***Notice to Employee.*** Any person who claims he or she has been denied a benefit under the Plan shall be entitled, upon written request to the Employer to receive, within thirty (30) days of receipt of such request, a written notice of such action, together with a full and clear statement of the specific reasons therefore, citing pertinent provisions of the Plan and statement of the procedure to be followed in requesting a review of his or her claim.

6.02 ***Appeal of Denial of Benefit.*** If the claimant wishes further consideration of his or her claim, he or she may request a hearing. The Employer shall schedule and hold a full and fair hearing on the issue within sixty (60) days following receipt of the claimant's request for such hearing. The decision following such hearing shall be communicated in writing to the claimant and, if the claim is denied, shall set forth the specific reasons for such denial, citing the pertinent provisions of the Plan. The decision of the Employer as to all claims shall be final. A person may make an appeal under this Section only with regard to benefits that have been denied under this Plan. Benefits provided under other benefit plans are not subject to appeal under this Section.

ARTICLE VII AMENDMENT OR TERMINATION OF THE PLAN

7.01 ***Right to Amend or Terminate.*** The Employer reserves the power at any time and from time to time (and retroactively if necessary or appropriate to meet the requirements of the Code) to modify or amend, in whole or in part, any or all of the provisions of the Plan provided, however, that no such modification or amendment shall divest a Participant of a right to a benefit to which he becomes entitled in accordance with the Plan. The Employer reserves the power to discontinue or terminate the Plan at any time. Any such amendment, discontinuance or termination shall be effective as of such date as the Employer shall determine.

ARTICLE VIII GENERAL PROVISIONS

8.01 ***Employment Rights.*** Neither the Plan nor any action taken with respect to it shall confer upon

any person the right to continue in the employ of the Employer.

8.02 ***Alienation of Benefits.*** No benefit under the Plan is subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, any attempt to do so is void.

8.03 ***Use of Form Required.*** All communications in connection with the Plan made by a Participant are effective only when duly executed on forms provided by and filed with the Division of Human Resources of the Employer.

8.04 ***Applicable Law.*** The provisions of the Plan shall be construed, administered and enforced according to applicable Federal law and the laws of the State of Utah.

8.05 ***Limitation on Liability.*** The Employer does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under such policy or contract.

8.06 ***Gender and Number.*** The masculine pronoun wherever used shall include the feminine, the neuter pronoun shall include both the masculine and the feminine, and the singular may include the plural, and vice versa, as the context may require.

The Employer does hereby establish this Plan for the benefit of its Employees, which shall be known as the Insurance Premium Payment Plan.

The undersigned does hereby certify that this Plan Document was approved and duly adopted on behalf of the GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT.

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

Date _____ By: _____

Title:

Attested:

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

LIMITED 125 CAFETERIA PLAN (FLEX$)

Summary Plan Document

Administered by Public Employees Health Program (PEHP)
560 East 200 South, Suite 110, Salt Lake City, Utah 84102-2004

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INTRODUCTION

Most of us have health care expenses that health insurance does not cover. In addition, many of us pay a considerable amount of money each year for dependent day care expenses. These out-of-pocket expenses take a big bite out of our take home pay. That's why your Employer has expanded its employee benefits program by offering THE LIMITED 125 CAFETERIA PLAN, administered by the Public Employees Health Program (PEHP). The Cafeteria Plan saves you money and helps your pay go farther. This plan was established to be used only with a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA). A general 125 cafeteria plan is available for use with the other health insurance plans.

This document briefly describes advantages and special rules that apply to the Limited Cafeteria Plan. Please read it carefully. It will help you understand how the program works so that you can take full advantage of its many attractive features. If there is anything you do not understand, contact the PEHP, at (801) 366-7503 or (800) 753-7751.

HOW THE LIMITED CAFETERIA PLAN WORKS

The Limited Cafeteria Plan program increases your spendable income by reducing your taxes. It accomplishes this by allowing you to use "before-tax" dollars to pay for specific out-of-pocket health care and dependent day care expenses. Employees who do not participate in the Cafeteria Plan program will pay the same type of expenses with "after-tax" dollars.

The difference between "before-tax" and "after-tax" dollars is very important. "Before-tax" dollars is your gross pay before Federal, State, and Social Security taxes are calculated and deducted. "After-tax" dollars is the net amount remaining after all taxes have been deducted from your pay. It makes good sense to use "before-tax" dollars to pay for eligible health care and dependent day care expenses.

CAUTION SHOULD BE USED IN DETERMINING THE AMOUNT TO BE DEDUCTED FROM YOUR PAYCHECK FOR THE LIMITED HEALTH CARE AND DEPENDENT DAY CARE ACCOUNTS, AS UNUSED FUNDS CANNOT BE RETURNED.

Limited Cafeteria Plan Reimbursement Accounts

This plan allows tax free contributions to an HSA if the other requirements are met. Total contributions to all HSA accounts for an eligible individual are limited by the IRS based on the type of HDHP coverage you have elected. The maximum contribution limits may change from year to year. Remember that contributions made by your employer count against that maximum. HSA accounts belong to the individual. The balances are carried forward from year to year and have investment earnings. Be sure to refer to other documents on HSA accounts regarding contributions, access, distributions, and tax reporting requirements.

There are two other types of accounts you may use when participating in the

Limited Cafeteria Plan program: one for health care, (limited to dental, vision, and preventive care), and one for dependent day care. You can open one, the other, or both! You decide how much you want to set aside in an account for the plan year, up to the allowed $2,700 maximum for health and $5,000 for dependent day care. Through payroll deductions, money is conveniently and automatically deposited into Cafeteria Plan Reimbursement Accounts each pay period throughout the year, before Federal, State, and Social Security taxes are computed. The minimum contribution necessary to participate is $130.00 per plan year.

PEHP provides benefit cards with medical reimbursement accounts. These cards are the most efficient method of using your medical flexible spending contributions. If you have a limited health account and an HSA, charges on the card are screened for dental and vision expenses. Dental and vision expenses are charged to the limited health account to the extent of available balance (annual election less any prior reimbursements from the account). Any card charges that do not qualify as dental or vision, or that exceed the available balance, are charged to the HSA account. Preventive care expenses that you want reimbursed from the limited health account should be paid for by some other means and submitted to the PEHP FLEX$™ department for reimbursement.

NO ELIGIBILITY VERIFICATION IS MADE FOR CARD CHARGES AND/OR DISBURSEMENTS TAKEN FROM THE HSA ACCOUNT. It is the participant's responsibility to determine the eligibility of the expenses. Contributions and disbursements from the HSA account are reported to the IRS. The participant must maintain records and report the eligibility of expenses on their federal tax return.

The Cafeteria Plan Can Save You Money

The Cafeteria Plan saves you money because the money contributed to a Cafeteria Plan Reimbursement Account is not taxed. Cafeteria Plan deductions are taken out of your gross pay before Federal, State, and Social Security taxes are calculated. This means that your taxable income (the income reflected on your annual W-2 form) is lowered. By lowering your taxable income, you'll pay less tax and have more money to spend.

Here's an example of how this works. . .

Susan and Glen both earn $40,000 a year, and pay out of their own pocket $400 for health care and $2,000 for dependent care incurred during the year. Susan decides to enroll in a FLEX$™ Health Care and Dependent Care Account. Glen decides not to participate in either FLEX$™ account, but claims the dependent childcare credit on his tax return.

	Susan	Glen
Annual taxable pay	$40,000	$40,000
Before-tax FLEX$™ contributions (health care and dependent care expense)	-2,400	-0-
Taxable Income	$37,600	$40,000
Estimated Utah Income Taxes (7.2%)	-2,707	-2,880
Soc Sec Taxes (7.65%)	-2,876	-3,060

Estimated Federal Income (15%)	-5,640	-6,000
Take-home pay	$26,377	$28,060
After-tax payment of health care and dependent day care expenses	-0-	-2,400
Federal Tax Credit / Child Care	-0-	400
Remaining annual spendable income	$26,377	$26,060
Increase in spendable income	$ 317	

By using the FLEX$™ Reimbursement Accounts, Susan saves $314 in taxes. Glen, on the other hand, is taxed on his full pay. This means that Susan has $314 more in spendable income, even after paying the same $2,400 in expenses that Glen paid. Why pay more taxes than you have to? It makes good sense to use a FLEX$™ Reimbursement Account to pay for eligible health care and dependent care expenses.

Of course, the increase in spendable income will vary depending upon the amount that you decide to set aside and your own individual tax situation.

Immediate Tax Savings

Since The Cafeteria Plan contributions are deducted every pay period, in equal installments throughout the year, your tax savings are immediate--not just when your tax return is filed at the end of the year. Expenses reimbursed with tax-free dollars from a Cafeteria Plan account may not be claimed again as an itemized tax deduction on your annual tax return. Expenses reimbursed from a limited health account cannot be used to justify disbursements from the HSA account. In other words, you cannot claim your expenses twice.

YOUR LIMITED CAFETERIA PLAN HEALTH CARE REIMBURSEMENT ACCOUNT

You can set aside any amount, up to $2,700 a year, in a Limited Cafeteria Plan Health Care Reimbursement Account. This tax-free money is used to reimburse you for eligible dental, vision, and/or preventive care expenses. To be eligible for reimbursement, you must incur an eligible expense on or after your effective date of coverage and during the allowable period for the plan year in which you are participating in a Limited Cafeteria Plan Health Care Reimbursement Account. Expenses may be for you or any other person who satisfies the definition of an eligible dependent. Eligible dependents include anyone who qualifies as a dependent for tax purposes under the Internal Revenue Code.

You should only contribute enough money to a Limited Health Care Reimbursement Account to cover the dental, vision, and preventive care expenses that you will incur during the plan year. Since coverage and co-payments vary depending upon which health insurance plan in which you or your dependents are enrolled, consult your plan document for information on coverage limitations AND exclusions. Remember, any money you elect to have deducted into the Limited Health Care Reimbursement Account may be forfeited if you are unable or choose not to claim it

within the plan period guidelines. **ALL EXPENSES ELIGIBLE FOR REIMBURSEMENT FROM THE LIMITED HEALTH CARE ACCOUNT ARE ALSO ELIGIBLE FOR REIMBURSEMENT FROM THE HSA ACCOUNT. YOU SHOULD MAXIMISE CONTRIBUTIONS TO THE HSA ACCOUNT BEFORE CONTRIBUTING MONEY TO A LIMITED HEALTH CARE ACCOUNT.**

Eligible Health Care Expenses

Here is a partial listing of the type of expenses which may qualify for reimbursement under a Limited Cafeteria Plan Health Care Reimbursement Account:

Medical

- Preventive care

Dental

- Bridges
- Cleaning Teeth
- Crowns
- Dental X-rays
- Dentures
- Extracting Teeth
- Fillings
- Fluoride Treatments
- Gum Treatments
- Oral Surgery
- Orthodontics
- TMJ

Vision

- Eye Exams
- Eyeglasses
- Contact Lenses, including lens care supplies
- Laser Eye Surgery
- Instruction, Training, and Equipment for the Blind

For more information, please consult IRS Publication 969.

Health Care and Taxes

Unless your out-of-pocket health care expenses exceed 7.5% of your total adjusted gross income, you will not be able to claim them on your Federal tax return. For instance, if your adjusted gross income is $18,000, your health care expenses must exceed $1,350 and then only the expenses exceeding $1,350 can be deducted. Non-prescription drugs and bandages cannot be included in itemized medical expenses on your tax return, but they are reimbursable from a HSA account.

YOUR CAFETERIA PLAN DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

The amount that you can contribute to a Cafeteria Plan Dependent Day Care Reimbursement Account depends upon whether you are married or single. If you are married, tax laws require that both you and your spouse be employed to use a Dependent Day Care Reimbursement Account (see exception noted below).

- If you are single, you can set aside up to $5,000 a year in a tax-free Dependent Day Care Reimbursement Account.
- If you are married and file a separate tax return, you can put up to $2,500 into a Dependent Day Care Reimbursement Account.
- If you are married and file a joint tax return, the maximum contribution is the lesser of your two incomes, up to a $5,000 limit. For example, suppose you earn $18,000 a year and your spouse earns $4,000, the maximum amount that could be payroll deducted for the Cafeteria Plan Dependent Day Care account is $4,000.

To be eligible for reimbursement:

- An expense must be incurred on or after your effective date of coverage
- It must occur during the period for the plan year in which you are participating in a Cafeteria Plan Dependent Day Care Reimbursement Account
- It must qualify as an eligible expense under the program rules

As in the Limited Health Care Reimbursement Account, you should only contribute enough money to a Dependent Day Care Reimbursement Account to cover the eligible dependent day care expenses that you will incur during the plan year. Remember, any money you elect to have deducted into the account may be forfeited if you are unable or choose not to claim it within the plan period guidelines.

Eligible Dependent Day Care Expenses

The dependent or childcare costs that you incur, in order for you and your spouse (if applicable) to work, qualify as eligible expenses. In addition, if your spouse is disabled or attends school and is not able to care for your eligible dependents, costs incurred to care for your eligible dependents may also be covered. Eligible dependents include anyone who qualifies as a dependent for tax purposes under the Internal Revenue Code. You may not use a Dependent Day Care Reimbursement Account to pay for babysitting expenses for a social event or for the cost of sending your child to an overnight camp.

Also excluded is any expense that is excluded by federal regulations including but not limited to food, clothing, or educational services unless these services are minimal or insignificant and inseparable from the portion of the expense that is for care, or for the individual's well being and protection. Educational services where the primary purpose is education, not care, include, but are not limited to, elementary and secondary schools, summer schools, continuing education classes, etc.

Some examples of eligible expenses are:

- A qualified day care center, nursery school, babysitter, or nurse.
- A maid or cook, if part of their job is to care for a person who qualifies for dependent day care.

- A relative who provides dependent day care, if the relative is not your dependent for income tax purposes or your child or stepchild under age 19.

To qualify for reimbursement under this program, your dependent children must be under age 13.

- Dependents that are age 13 or older must be totally disabled and spend at least eight hours each day in your home.
- If dependent day care services are provided by a day care facility that cares for more than six children at once, it must be a state licensed day care center.
- You must furnish the name, address and taxpayers' identification number (Social Security number) of each day care facility or private individual that provides care on each Cafeteria Plan claim submitted.(1)

Dependent Day Care and Taxes

You can save on taxes with eligible dependent day care expenses in two different ways: you may be entitled to a tax credit on your individual tax return, and/or you may participate in a Cafeteria Plan Dependent Day Care Reimbursement Account.

There is a maximum Federal tax credit available for dependent day care expenses. (Please note: the available tax credit and the additional savings realized on Social Security and State taxes, by participation in a Cafeteria Plan Dependent Day Care Reimbursement Account may result in greater tax savings than the Federal tax credit. Generally speaking, families earning around $25,000 or more are better off using a Dependent Day Care Reimbursement Account.) Participation in a Dependent Day Care Reimbursement Account would also benefit certain low-income families (i.e., families who have adjusted gross incomes which result in no Federal income tax liability, do not benefit from a tax credit, but would save on Social Security taxes).

Expenses claimed through a Cafeteria Plan account cannot be claimed again as a yearend tax credit; however, that portion of eligible expenses not claimed through The Cafeteria Plan may be eligible for a yearend tax credit. Before making your final decision about participation in a Cafeteria Plan Dependent Day Care Reimbursement Account, please consult a tax professional.

HOW THE CAFETERIA PLAN AFFECTS YOUR OTHER BENEFITS

Many of the benefits that you receive are based upon your salary. Included in this category are disability coverage, retirement, social security, and deferred compensation. Of these, the only benefits that could possibly be affected by your participation in The Cafeteria Plan are social security and deferred compensation.

Social Security

Since The Limited Cafeteria Plan contributions are deducted on a before-tax basis, they are not included in your F.I.C.A. taxable wages. As a result, your Social Security benefit at retirement may be reduced, but only slightly. With the changes in Social Security benefits and taxes, and with the increasing age at which employees can

receive Social Security retirement benefits, the calculation of the actual impact may be different for each individual. However, the savings in taxes more than make up for the small loss of Social Security benefits at retirement. If you want to know the actual impact on your benefits, contact the Social Security Administration.

Deferred Compensation

Additional tax savings may be realized if you choose to participate in both The Limited Cafeteria Plan and one of the Deferred Compensation Plans (DCP), either a 401(k),457or 403(b). Income, for DCP purposes, means your income remaining after all tax-free and tax-deferred deductions have been taken. Since The Cafeteria Plan contributions are tax-free, the maximum DCP contribution that you are allowed to make may be lower than anticipated depending on the amount of The Limited Cafeteria Plan contribution. Please call the Public Employees Health Program (801) 366-7503 if you have any questions regarding the Limited Cafeteria Plan program affect on DCP. However, remember that dollars directed to 401(k), 457 or 403(b) plans also reduce your State and Federal tax withholdings (but not FICA withholdings).

CAFETERIA PLAN ELIGIBILITY AND ENROLLMENT

All HDHP medical insurance eligible employees may enroll and participate in the Limited Cafeteria Plan program. If you are unsure whether you are eligible to participate or not, check with your payroll person.

The annual open enrollment period will be held in the month November for the following plan year. To participate in an upcoming year, you must enroll on line at www.pehp.org or return a completed enrollment form to the Public Employees Health Program, 560 East 200 South, Suite 100, Salt Lake City, UT 84102-2004 by the end of the enrollment period. You must re-enroll each year that you wish to participate in the Cafeteria Plan program. This gives you the opportunity to evaluate your needs for the new period and possibly change your elected deduction amounts. Enrollment forms should be requested from your Employer.

New employees may enroll within the first 60 days of their employment by enrolling online, when available, or providing the Public Employees Health Program with a completed enrollment form and verification of hire date.

Employees who have a change in family status (i.e., marriage, divorce, birth of a child, etc.) may enroll within 60 days of the event. Proper documentation (marriage license, birth certificate, divorce decree, etc.) and a completed Cafeteria Plan application must be received by the Public Employees Health Program within 60 days of the change in family status.

It is then the employee's responsibility to monitor their own paycheck stubs to see that the intended change occurs. If the expected change does not take place, the employee must contact their payroll department or Public Employees Health Program (801) 366-7503 immediately so that adjustments can be made.

Every employee who is eligible and enrolls in the Limited Cafeteria Plan may be

assessed a fee if the employer elects for the employees to pay the fees. This fee will be charged to the Spending Account of the Participant from which such reimbursement is made.

EFFECTIVE DATE OF COVERAGE

When you enroll in The Cafeteria Plan during the November open enrollment period, your coverage becomes effective on January 1st, the start of the next plan year. For new employees who enroll within the first 60 days of their employment, coverage becomes effective when they enroll. If an employee, following a change in family status (i.e. marriage, divorce, birth of a child, etc.):

- enrolls in a Limited Cafeteria Plan account, coverage is effective on the date that the family status change occurred.
- chooses to increase contributions to an existing Limited Cafeteria Plan account; the original effective date of coverage for the current plan year applies to the increased amount.
- wishes to decrease or stop payroll deductions to an existing Cafeteria Plan account, there is no change to the effective date of coverage.

You may submit claims for eligible expenses incurred on or after the effective date of coverage for the plan period in which you are enrolled.

CHANGING YOUR CAFETERIA PLAN DEDUCTIONS

The payroll deduction that you choose for The Limited Health and Dependent Day Care accounts may not be changed during the course of a year unless you have a change in status, change in your family's status (i.e., marriage, divorce, birth of a child, etc.) and/or change in your employment status. Within 60 days of the change in status you are required to furnish the Public Employees Health Program 560 East 200 South, Suite 100, Salt Lake City, UT 84102-2004 with proper documentation (marriage license, birth certificate, divorce decree, etc.) and complete a new Cafeteria Plan application. Payroll deductions may be started, stopped, increased or decreased if one of the above status changes occur. However, the change in the new election must be consistent with the status change.

HSA CONTRIBUTIONS MAY BE CHANGED AT ANY TIME.

In addition, money cannot be transferred between Cafeteria Plan accounts. There are strict government rules, which state that the money contributed to each account must remain completely separate and dedicated to its original elected purpose.

FLEX$TM CLAIM AND REIMBURSEMENT PROCESS

FLEX$TM covers eligible health care and dependent day care expenses that are incurred in the plan year or by March 15th after the plan year that you are enrolled. This means that treatment and/or services must be provided on or after your effective

date of coverage, during the plan year that you are a participant or by the next March 15th. The date that an expense was paid has no bearing on whether or not it is eligible under the program.

You may use the benefit card provided to pay for medical expenses or pay for them with your funds and request reimbursement. Whenever you have verification of an eligible expense for which you have not used the card or for dependent day care expenses, you must complete a FLEX$™ claim to receive reimbursement. Claim forms may be obtained from your department payroll clerk or from the PEHP web site. Claims will be processed within two business days of receipt and paid by direct deposit or check. FLEX$™ reimbursements will not be considered part of your taxable income for the year.

HSA distributions can be made under the rules of the HSA account and do not require documentation. You will need to maintain the documentation for and with your tax return.

Claim Submission Deadlines

PEHP processes paper claims with in two days of receipt. Direct deposit and check payments will be made at least twice a week. You have 90 days following the end of the plan year to submit claims to the Public Employees Health Program for reimbursement of health care and/or dependent day care expenses incurred for the previous plan year.

Claim Documentation

When submitting FLEX$™ claims, each expense that you claim under FLEX$™ must be supported by appropriate documentation. Appropriate documentation includes good quality copies of original: receipts, statements, OR any other document that shows the name of the provider, the service date, the type of service, the service recipient, and the amount of your total out-of-pocket expense.

It is recommended that you keep your own original receipts of service and billings, regardless of whether the card was used or you paid by other means. A personal record should be kept of exactly what you have submitted. This is especially important because the Public Employees Health Program is unable to provide you with copies of The Limited Cafeteria Plan claims and claims documentation.

If the required information is not on the claim, the claim may be rejected and sent back to you. The minimum required data includes: social security number, employee name and address information, date(s) of service received, type of service received, service provider, and amount of the claim. In addition, the claim MUST be signed, and if you are submitting a dependent day care claim, the provider's tax ID number must be provided.

Dependent Day Care Claims

Acceptable documentation for dependent day care expenses are copies of provider issued receipts or statements. PLEASE NOTE: To comply with new Federal tax law, the provider's name, address and taxpayer identification number (Social Security number) must be listed on each dependent day care claim. This information should be noted in the "NAME OF PROVIDER AND TAX ID#" section of the Cafeteria

Plan Reimbursement claim form.

While the card is not available for dependent day care, we do have a process for automatic reimbursement. The participant with on going, month to month expenses can submit a request form with provider data at the first of the year. When accepted, PEHP will reimburse the payroll contributions by direct deposit at the next payment process after receipt of the contributions from the employer. No other documentation or requests need to be provided until the end of the year. At the end of the year, the participant will provide PEHP with a statement or receipts from the provider showing the total charges for the year. The participant must sign up for direct deposit to participate in automatic reimbursement.

Denied Cafeteria Plan Claims

Denied Cafeteria Plan claims may be appealed. Appeals must be received in writing, along with any supporting documentation, by the PEHP within 60 days of the denial notification. The PEHP will then respond within 60 days of receipt of your appeal.

Participants will be informed of all claims denied by the PEHP as being ineligible for reimbursement. Participants may not necessarily be informed if reimbursement is not forthcoming due to the amount claimed being more than the amount chosen as the elected deduction amount, for dependant day care.

With the Dependent Day Care Account, participants are only allowed reimbursement for the amount they have contributed.

With the Health Care Reimbursement Account, participants can only be reimbursed for the amount they have elected to contribute during the plan year.

Name and Address Changes

Employees are responsible for informing their own payroll/human resource department whenever there is a name and/or address change. Employees should then monitor their paychecks to verify that the name and/or address change takes place within the payroll system. Employees must include the correct home address on the claim. Failure to do so may result in delays in receiving Cafeteria Plan reimbursements. This can be avoided by signing up for direct deposit.

Duplicate Reimbursement/Overpayment

If reimbursement from cafeteria plan and any other source exceeds 100% of a health care or dependent day care expense, the Public Employees Health Program will either require you to refund the excess amount or will adjust future claim payment(s). In the event that your cafeteria plan reimbursements exceed the total amount that you have contributed for the year, you will be required to refund the difference within 15 days after notification by the Public Employees Health Program.

Termination of Employment/Employment Status Change

If your employment terminates, you retire, or you go from an eligible to an ineligible status during the year, you may either pre-pay the remaining obligation under the Salary Reduction Agreement, chose to continue your cafeteria plan benefit by filing out a COBRA enrollment form, or revoke all existing benefit elections and terminate your entitlement to the reimbursement of expenses incurred during the Plan Year.

A Participant who separates from service may elect to pre-pay the remaining obligation under the current Salary Reduction Agreement. The Participant may then apply for reimbursement throughout the end of that Plan Year.

If a Participant who separates from service elects COBRA, they will continue to make contributions to the Plan to provide for the funding of Benefits for the remainder of that Plan Year. If the individual (Qualified Beneficiary (QB)) who elects COBRA fails to timely make any required contributions, that QB shall not be entitled to reimbursements for the portion of the Plan Year for which contributions were not made. (Refer to COBRA requirements under Article 8 of the Plan Document)

In the event of your death, reimbursement for eligible expenses may be filed by your dependents (if any) until your accumulated contributions have been exhausted. In no event, however, will reimbursement be made for claims received after the applicable Cafeteria Plan claims submission deadlines.

A Participant, who separates from service and then returns to service as an Eligible Employee within 30 days, may have the previous election automatically reinstated for the remainder of that Plan Year. If the former Participant returns to service as an Eligible Employee after 30 days, the Employee may make a new election or resume the previous election for the remainder of that Plan Year.

BEFORE YOU DECIDE

Take some time to think about the health care needs of your family. Review last year's preventive care medical, dental, and vision expenses and those from the year before. Then, estimate your out-of-pocket expenses for the upcoming year considering what your medical and/or dental plan(s) cover and what portion you must pay.

If you pay for dependent day care, estimate the amount you expect to pay over the next year. Consider any changes that will occur in dependent day care costs and in the number of eligible dependents you may claim. Remember to take into account such predictable events as family vacations, children entering school, etc.
Cafeteria Plan Reimbursement Accounts should only be used for expenses that you can accurately predict. Ask yourself these questions. . .

Does anyone in my family wear contacts or glasses?
Do my children need orthodontia?
Do I pay for the care of an incapacitated spouse or dependent parent?
Do I have young children who need day care so I can work?
Do I pay a housekeeper to care for my child part of the day?

If you answer YES to any of the above questions, a Cafeteria Plan Reimbursement Account may be right for you. Why not pay your predictable health care and dependent day care expenses with tax-free money?

ABOUT THIS DOCUMENT

This document summarizes the major features of the 125 Cafeteria Plan (Cafeteria Plan). It is recommended that you attempt to refer to the most recent printing of this material occasionally during the plan year. Every effort has been made to make sure this information is clear, easy to understand and accurate. The official plan document contains complete plan provisions and is available for inspection, upon request, through your Employer, or at the Public Employee Health Program Office. In case of any discrepancy between this document and the official plan document, the official plan document will take precedence.

FOR ADDITIONAL INFORMATION

For further clarification of the concepts and rules contained within this document, or if you are experiencing any problem with your Cafeteria Plan accounts, please contact the Public Employees Health Program, FLEX$™ Plan Administration, 560 East 200 South, Suite 110, Salt Lake City, Utah 84102-2004 at (801) 366-7503 or (800) 753-7751.

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

LIMITED 125 CAFETERIA PLAN (FLEX$)

Summary Plan Document

Administered by Public Employees Health Program (PEHP)
560 East 200 South, Suite 110, Salt Lake City, Utah 84102-2004

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INTRODUCTION

Most of us have health care expenses that health insurance does not cover. In addition, many of us pay a considerable amount of money each year for dependent day care expenses. These out-of-pocket expenses take a big bite out of our take home pay. That's why your Employer has expanded its employee benefits program by offering THE LIMITED 125 CAFETERIA PLAN, administered by the Public Employees Health Program (PEHP). The Cafeteria Plan saves you money and helps your pay go farther. This plan was established to be used only with a High Deductible Health Plan (HDHP) and a Health Savings Account (HSA). A general 125 cafeteria plan is available for use with the other health insurance plans.

This document briefly describes advantages and special rules that apply to the Limited Cafeteria Plan. Please read it carefully. It will help you understand how the program works so that you can take full advantage of its many attractive features. If there is anything you do not understand, contact the PEHP, at (801) 366-7503 or (800) 753-7751.

HOW THE LIMITED CAFETERIA PLAN WORKS

The Limited Cafeteria Plan program increases your spendable income by reducing your taxes. It accomplishes this by allowing you to use "before-tax" dollars to pay for specific out-of-pocket health care and dependent day care expenses. Employees who do not participate in the Cafeteria Plan program will pay the same type of expenses with "after-tax" dollars.

The difference between "before-tax" and "after-tax" dollars is very important. "Before-tax" dollars is your gross pay before Federal, State, and Social Security taxes are calculated and deducted. "After-tax" dollars is the net amount remaining after all taxes have been deducted from your pay. It makes good sense to use "before-tax" dollars to pay for eligible health care and dependent day care expenses.

CAUTION SHOULD BE USED IN DETERMINING THE AMOUNT TO BE DEDUCTED FROM YOUR PAYCHECK FOR THE LIMITED HEALTH CARE AND DEPENDENT DAY CARE ACCOUNTS, AS UNUSED FUNDS CANNOT BE RETURNED.

Limited Cafeteria Plan Reimbursement Accounts

This plan allows tax free contributions to an HSA if the other requirements are met. Total contributions to all HSA accounts for an eligible individual are limited by the IRS based on the type of HDHP coverage you have elected. The maximum contribution limits may change from year to year. Remember that contributions made by your employer count against that maximum. HSA accounts belong to the individual. The balances are carried forward from year to year and have investment earnings. Be sure to refer to other documents on HSA accounts regarding contributions, access, distributions, and tax reporting requirements.

There are two other types of accounts you may use when participating in the

Limited Cafeteria Plan program: one for health care, (limited to dental, vision, and preventive care), and one for dependent day care. You can open one, the other, or both! You decide how much you want to set aside in an account for the plan year, up to the allowed $2,700 maximum for health and $5,000 for dependent day care. Through payroll deductions, money is conveniently and automatically deposited into Cafeteria Plan Reimbursement Accounts each pay period throughout the year, before Federal, State, and Social Security taxes are computed. The minimum contribution necessary to participate is $130.00 per plan year.

PEHP provides benefit cards with medical reimbursement accounts. These cards are the most efficient method of using your medical flexible spending contributions. If you have a limited health account and an HSA, charges on the card are screened for dental and vision expenses. Dental and vision expenses are charged to the limited health account to the extent of available balance (annual election less any prior reimbursements from the account). Any card charges that do not qualify as dental or vision, or that exceed the available balance, are charged to the HSA account. Preventive care expenses that you want reimbursed from the limited health account should be paid for by some other means and submitted to the PEHP FLEX$™ department for reimbursement.

NO ELIGIBILITY VERIFICATION IS MADE FOR CARD CHARGES AND/OR DISBURSEMENTS TAKEN FROM THE HSA ACCOUNT. It is the participant's responsibility to determine the eligibility of the expenses. Contributions and disbursements from the HSA account are reported to the IRS. The participant must maintain records and report the eligibility of expenses on their federal tax return.

The Cafeteria Plan Can Save You Money

The Cafeteria Plan saves you money because the money contributed to a Cafeteria Plan Reimbursement Account is not taxed. Cafeteria Plan deductions are taken out of your gross pay before Federal, State, and Social Security taxes are calculated. This means that your taxable income (the income reflected on your annual W-2 form) is lowered. By lowering your taxable income, you'll pay less tax and have more money to spend.

Here's an example of how this works. . .

Susan and Glen both earn $40,000 a year, and pay out of their own pocket $400 for health care and $2,000 for dependent care incurred during the year. Susan decides to enroll in a FLEX$™ Health Care and Dependent Care Account. Glen decides not to participate in either FLEX$™ account, but claims the dependent childcare credit on his tax return.

	Susan	Glen
Annual taxable pay	$40,000	$40,000
Before-tax FLEX$™ contributions (health care and dependent care expense)	-2,400	-0-
Taxable Income	$37,600	$40,000
Estimated Utah Income Taxes (7.2%)	-2,707	-2,880
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Federal Tax Credit / Child Care	-0-	400
Remaining annual spendable income	$26,377	$26,060
Increase in spendable income	$ 317	

By using the FLEX$™ Reimbursement Accounts, Susan saves $314 in taxes. Glen, on the other hand, is taxed on his full pay. This means that Susan has $314 more in spendable income, even after paying the same $2,400 in expenses that Glen paid. Why pay more taxes than you have to? It makes good sense to use a FLEX$™ Reimbursement Account to pay for eligible health care and dependent care expenses.

Of course, the increase in spendable income will vary depending upon the amount that you decide to set aside and your own individual tax situation.

Immediate Tax Savings

Since The Cafeteria Plan contributions are deducted every pay period, in equal installments throughout the year, your tax savings are immediate--not just when your tax return is filed at the end of the year. Expenses reimbursed with tax-free dollars from a Cafeteria Plan account may not be claimed again as an itemized tax deduction on your annual tax return. Expenses reimbursed from a limited health account cannot be used to justify disbursements from the HSA account. In other words, you cannot claim your expenses twice.

YOUR LIMITED CAFETERIA PLAN HEALTH CARE REIMBURSEMENT ACCOUNT

You can set aside any amount, up to $2,700 a year, in a Limited Cafeteria Plan Health Care Reimbursement Account. This tax-free money is used to reimburse you for eligible dental, vision, and/or preventive care expenses. To be eligible for reimbursement, you must incur an eligible expense on or after your effective date of coverage and during the allowable period for the plan year in which you are participating in a Limited Cafeteria Plan Health Care Reimbursement Account. Expenses may be for you or any other person who satisfies the definition of an eligible dependent. Eligible dependents include anyone who qualifies as a dependent for tax purposes under the Internal Revenue Code.

You should only contribute enough money to a Limited Health Care Reimbursement Account to cover the dental, vision, and preventive care expenses that you will incur during the plan year. Since coverage and co-payments vary depending upon which health insurance plan in which you or your dependents are enrolled, consult your plan document for information on coverage limitations AND exclusions. Remember, any money you elect to have deducted into the Limited Health Care Reimbursement Account may be forfeited if you are unable or choose not to claim it

within the plan period guidelines. **ALL EXPENSES ELIGIBLE FOR REIMBURSEMENT FROM THE LIMITED HEALTH CARE ACCOUNT ARE ALSO ELIGIBLE FOR REIMBURSEMENT FROM THE HSA ACCOUNT. YOU SHOULD MAXIMISE CONTRIBUTIONS TO THE HSA ACCOUNT BEFORE CONTRIBUTING MONEY TO A LIMITED HEALTH CARE ACCOUNT.**

Eligible Health Care Expenses

Here is a partial listing of the type of expenses which may qualify for reimbursement under a Limited Cafeteria Plan Health Care Reimbursement Account:

Medical

- Preventive care

Dental

- Bridges
- Cleaning Teeth
- Crowns
- Dental X-rays
- Dentures
- Extracting Teeth
- Fillings
- Fluoride Treatments
- Gum Treatments
- Oral Surgery
- Orthodontics
- TMJ

Vision

- Eye Exams
- Eyeglasses
- Contact Lenses, including lens care supplies
- Laser Eye Surgery
- Instruction, Training, and Equipment for the Blind

For more information, please consult IRS Publication 969.

Health Care and Taxes

Unless your out-of-pocket health care expenses exceed 7.5% of your total adjusted gross income, you will not be able to claim them on your Federal tax return. For instance, if your adjusted gross income is $18,000, your health care expenses must exceed $1,350 and then only the expenses exceeding $1,350 can be deducted. Non-prescription drugs and bandages cannot be included in itemized medical expenses on your tax return, but they are reimbursable from a HSA account.

YOUR CAFETERIA PLAN DEPENDENT DAY CARE REIMBURSEMENT ACCOUNT

The amount that you can contribute to a Cafeteria Plan Dependent Day Care Reimbursement Account depends upon whether you are married or single. If you are married, tax laws require that both you and your spouse be employed to use a Dependent Day Care Reimbursement Account (see exception noted below).

- If you are single, you can set aside up to $5,000 a year in a tax-free Dependent Day Care Reimbursement Account.
- If you are married and file a separate tax return, you can put up to $2,500 into a Dependent Day Care Reimbursement Account.
- If you are married and file a joint tax return, the maximum contribution is the lesser of your two incomes, up to a $5,000 limit. For example, suppose you earn $18,000 a year and your spouse earns $4,000, the maximum amount that could be payroll deducted for the Cafeteria Plan Dependent Day Care account is $4,000.

To be eligible for reimbursement:

- An expense must be incurred on or after your effective date of coverage
- It must occur during the period for the plan year in which you are participating in a Cafeteria Plan Dependent Day Care Reimbursement Account
- It must qualify as an eligible expense under the program rules

As in the Limited Health Care Reimbursement Account, you should only contribute enough money to a Dependent Day Care Reimbursement Account to cover the eligible dependent day care expenses that you will incur during the plan year. Remember, any money you elect to have deducted into the account may be forfeited if you are unable or choose not to claim it within the plan period guidelines.

Eligible Dependent Day Care Expenses

The dependent or childcare costs that you incur, in order for you and your spouse (if applicable) to work, qualify as eligible expenses. In addition, if your spouse is disabled or attends school and is not able to care for your eligible dependents, costs incurred to care for your eligible dependents may also be covered. Eligible dependents include anyone who qualifies as a dependent for tax purposes under the Internal Revenue Code. You may not use a Dependent Day Care Reimbursement Account to pay for babysitting expenses for a social event or for the cost of sending your child to an overnight camp.

Also excluded is any expense that is excluded by federal regulations including but not limited to food, clothing, or educational services unless these services are minimal or insignificant and inseparable from the portion of the expense that is for care, or for the individual's well being and protection. Educational services where the primary purpose is education, not care, include, but are not limited to, elementary and secondary schools, summer schools, continuing education classes, etc.

Some examples of eligible expenses are:

- A qualified day care center, nursery school, babysitter, or nurse.
- A maid or cook, if part of their job is to care for a person who qualifies for dependent day care.

- A relative who provides dependent day care, if the relative is not your dependent for income tax purposes or your child or stepchild under age 19.

To qualify for reimbursement under this program, your dependent children must be under age 13.

- Dependents that are age 13 or older must be totally disabled and spend at least eight hours each day in your home.
- If dependent day care services are provided by a day care facility that cares for more than six children at once, it must be a state licensed day care center.
- You must furnish the name, address and taxpayers' identification number (Social Security number) of each day care facility or private individual that provides care on each Cafeteria Plan claim submitted.(1)

Dependent Day Care and Taxes

You can save on taxes with eligible dependent day care expenses in two different ways: you may be entitled to a tax credit on your individual tax return, and/or you may participate in a Cafeteria Plan Dependent Day Care Reimbursement Account.

There is a maximum Federal tax credit available for dependent day care expenses. (Please note: the available tax credit and the additional savings realized on Social Security and State taxes, by participation in a Cafeteria Plan Dependent Day Care Reimbursement Account may result in greater tax savings than the Federal tax credit. Generally speaking, families earning around $25,000 or more are better off using a Dependent Day Care Reimbursement Account.) Participation in a Dependent Day Care Reimbursement Account would also benefit certain low-income families (i.e., families who have adjusted gross incomes which result in no Federal income tax liability, do not benefit from a tax credit, but would save on Social Security taxes).

Expenses claimed through a Cafeteria Plan account cannot be claimed again as a yearend tax credit; however, that portion of eligible expenses not claimed through The Cafeteria Plan may be eligible for a yearend tax credit. Before making your final decision about participation in a Cafeteria Plan Dependent Day Care Reimbursement Account, please consult a tax professional.

HOW THE CAFETERIA PLAN AFFECTS YOUR OTHER BENEFITS

Many of the benefits that you receive are based upon your salary. Included in this category are disability coverage, retirement, social security, and deferred compensation. Of these, the only benefits that could possibly be affected by your participation in The Cafeteria Plan are social security and deferred compensation.

Social Security

Since The Limited Cafeteria Plan contributions are deducted on a before-tax basis, they are not included in your F.I.C.A. taxable wages. As a result, your Social Security benefit at retirement may be reduced, but only slightly. With the changes in Social Security benefits and taxes, and with the increasing age at which employees can

receive Social Security retirement benefits, the calculation of the actual impact may be different for each individual. However, the savings in taxes more than make up for the small loss of Social Security benefits at retirement. If you want to know the actual impact on your benefits, contact the Social Security Administration.

Deferred Compensation

Additional tax savings may be realized if you choose to participate in both The Limited Cafeteria Plan and one of the Deferred Compensation Plans (DCP), either a 401(k),457or 403(b). Income, for DCP purposes, means your income remaining after all tax-free and tax-deferred deductions have been taken. Since The Cafeteria Plan contributions are tax-free, the maximum DCP contribution that you are allowed to make may be lower than anticipated depending on the amount of The Limited Cafeteria Plan contribution. Please call the Public Employees Health Program (801) 366-7503 if you have any questions regarding the Limited Cafeteria Plan program affect on DCP. However, remember that dollars directed to 401(k), 457 or 403(b) plans also reduce your State and Federal tax withholdings (but not FICA withholdings).

CAFETERIA PLAN ELIGIBILITY AND ENROLLMENT

All HDHP medical insurance eligible employees may enroll and participate in the Limited Cafeteria Plan program. If you are unsure whether you are eligible to participate or not, check with your payroll person.

The annual open enrollment period will be held in the month November for the following plan year. To participate in an upcoming year, you must enroll on line at www.pehp.org or return a completed enrollment form to the Public Employees Health Program, 560 East 200 South, Suite 100, Salt Lake City, UT 84102-2004 by the end of the enrollment period. You must re-enroll each year that you wish to participate in the Cafeteria Plan program. This gives you the opportunity to evaluate your needs for the new period and possibly change your elected deduction amounts. Enrollment forms should be requested from your Employer.

New employees may enroll within the first 60 days of their employment by enrolling online, when available, or providing the Public Employees Health Program with a completed enrollment form and verification of hire date.

Employees who have a change in family status (i.e., marriage, divorce, birth of a child, etc.) may enroll within 60 days of the event. Proper documentation (marriage license, birth certificate, divorce decree, etc.) and a completed Cafeteria Plan application must be received by the Public Employees Health Program within 60 days of the change in family status.

It is then the employee's responsibility to monitor their own paycheck stubs to see that the intended change occurs. If the expected change does not take place, the employee must contact their payroll department or Public Employees Health Program (801) 366-7503 immediately so that adjustments can be made.

Every employee who is eligible and enrolls in the Limited Cafeteria Plan may be

assessed a fee if the employer elects for the employees to pay the fees. This fee will be charged to the Spending Account of the Participant from which such reimbursement is made.

EFFECTIVE DATE OF COVERAGE

When you enroll in The Cafeteria Plan during the November open enrollment period, your coverage becomes effective on January 1st, the start of the next plan year. For new employees who enroll within the first 60 days of their employment, coverage becomes effective when they enroll. If an employee, following a change in family status (i.e. marriage, divorce, birth of a child, etc.):

- enrolls in a Limited Cafeteria Plan account, coverage is effective on the date that the family status change occurred.
- chooses to increase contributions to an existing Limited Cafeteria Plan account; the original effective date of coverage for the current plan year applies to the increased amount.
- wishes to decrease or stop payroll deductions to an existing Cafeteria Plan account, there is no change to the effective date of coverage.

You may submit claims for eligible expenses incurred on or after the effective date of coverage for the plan period in which you are enrolled.

CHANGING YOUR CAFETERIA PLAN DEDUCTIONS

The payroll deduction that you choose for The Limited Health and Dependent Day Care accounts may not be changed during the course of a year unless you have a change in status, change in your family's status (i.e., marriage, divorce, birth of a child, etc.) and/or change in your employment status. Within 60 days of the change in status you are required to furnish the Public Employees Health Program 560 East 200 South, Suite 100, Salt Lake City, UT 84102-2004 with proper documentation (marriage license, birth certificate, divorce decree, etc.) and complete a new Cafeteria Plan application. Payroll deductions may be started, stopped, increased or decreased if one of the above status changes occur. However, the change in the new election must be consistent with the status change.

HSA CONTRIBUTIONS MAY BE CHANGED AT ANY TIME.

In addition, money cannot be transferred between Cafeteria Plan accounts. There are strict government rules, which state that the money contributed to each account must remain completely separate and dedicated to its original elected purpose.

FLEX$TM CLAIM AND REIMBURSEMENT PROCESS

FLEX$TM covers eligible health care and dependent day care expenses that are incurred in the plan year or by March 15th after the plan year that you are enrolled. This means that treatment and/or services must be provided on or after your effective

date of coverage, during the plan year that you are a participant or by the next March 15th. The date that an expense was paid has no bearing on whether or not it is eligible under the program.

You may use the benefit card provided to pay for medical expenses or pay for them with your funds and request reimbursement. Whenever you have verification of an eligible expense for which you have not used the card or for dependent day care expenses, you must complete a FLEX$™ claim to receive reimbursement. Claim forms may be obtained from your department payroll clerk or from the PEHP web site. Claims will be processed within two business days of receipt and paid by direct deposit or check. FLEX$™ reimbursements will not be considered part of your taxable income for the year.

HSA distributions can be made under the rules of the HSA account and do not require documentation. You will need to maintain the documentation for and with your tax return.

Claim Submission Deadlines

PEHP processes paper claims with in two days of receipt. Direct deposit and check payments will be made at least twice a week. You have 90 days following the end of the plan year to submit claims to the Public Employees Health Program for reimbursement of health care and/or dependent day care expenses incurred for the previous plan year.

Claim Documentation

When submitting FLEX$™ claims, each expense that you claim under FLEX$™ must be supported by appropriate documentation. Appropriate documentation includes good quality copies of original: receipts, statements, OR any other document that shows the name of the provider, the service date, the type of service, the service recipient, and the amount of your total out-of-pocket expense.

It is recommended that you keep your own original receipts of service and billings, regardless of whether the card was used or you paid by other means. A personal record should be kept of exactly what you have submitted. This is especially important because the Public Employees Health Program is unable to provide you with copies of The Limited Cafeteria Plan claims and claims documentation.

If the required information is not on the claim, the claim may be rejected and sent back to you. The minimum required data includes: social security number, employee name and address information, date(s) of service received, type of service received, service provider, and amount of the claim. In addition, the claim MUST be signed, and if you are submitting a dependent day care claim, the provider's tax ID number must be provided.

Dependent Day Care Claims

Acceptable documentation for dependent day care expenses are copies of provider issued receipts or statements. PLEASE NOTE: To comply with new Federal tax law, the provider's name, address and taxpayer identification number (Social Security number) must be listed on each dependent day care claim. This information should be noted in the "NAME OF PROVIDER AND TAX ID#" section of the Cafeteria

Plan Reimbursement claim form.

While the card is not available for dependent day care, we do have a process for automatic reimbursement. The participant with on going, month to month expenses can submit a request form with provider data at the first of the year. When accepted, PEHP will reimburse the payroll contributions by direct deposit at the next payment process after receipt of the contributions from the employer. No other documentation or requests need to be provided until the end of the year. At the end of the year, the participant will provide PEHP with a statement or receipts from the provider showing the total charges for the year. The participant must sign up for direct deposit to participate in automatic reimbursement.

Denied Cafeteria Plan Claims

Denied Cafeteria Plan claims may be appealed. Appeals must be received in writing, along with any supporting documentation, by the PEHP within 60 days of the denial notification. The PEHP will then respond within 60 days of receipt of your appeal.

Participants will be informed of all claims denied by the PEHP as being ineligible for reimbursement. Participants may not necessarily be informed if reimbursement is not forthcoming due to the amount claimed being more than the amount chosen as the elected deduction amount, for dependant day care.

With the Dependent Day Care Account, participants are only allowed reimbursement for the amount they have contributed.

With the Health Care Reimbursement Account, participants can only be reimbursed for the amount they have elected to contribute during the plan year.

Name and Address Changes

Employees are responsible for informing their own payroll/human resource department whenever there is a name and/or address change. Employees should then monitor their paychecks to verify that the name and/or address change takes place within the payroll system. Employees must include the correct home address on the claim. Failure to do so may result in delays in receiving Cafeteria Plan reimbursements. This can be avoided by signing up for direct deposit.

Duplicate Reimbursement/Overpayment

If reimbursement from cafeteria plan and any other source exceeds 100% of a health care or dependent day care expense, the Public Employees Health Program will either require you to refund the excess amount or will adjust future claim payment(s). In the event that your cafeteria plan reimbursements exceed the total amount that you have contributed for the year, you will be required to refund the difference within 15 days after notification by the Public Employees Health Program.

Termination of Employment/Employment Status Change

If your employment terminates, you retire, or you go from an eligible to an ineligible status during the year, you may either pre-pay the remaining obligation under the Salary Reduction Agreement, chose to continue your cafeteria plan benefit by filing out a COBRA enrollment form, or revoke all existing benefit elections and terminate your entitlement to the reimbursement of expenses incurred during the Plan Year.

A Participant who separates from service may elect to pre-pay the remaining obligation under the current Salary Reduction Agreement. The Participant may then apply for reimbursement throughout the end of that Plan Year.

If a Participant who separates from service elects COBRA, they will continue to make contributions to the Plan to provide for the funding of Benefits for the remainder of that Plan Year. If the individual (Qualified Beneficiary (QB)) who elects COBRA fails to timely make any required contributions, that QB shall not be entitled to reimbursements for the portion of the Plan Year for which contributions were not made. (Refer to COBRA requirements under Article 8 of the Plan Document)

In the event of your death, reimbursement for eligible expenses may be filed by your dependents (if any) until your accumulated contributions have been exhausted. In no event, however, will reimbursement be made for claims received after the applicable Cafeteria Plan claims submission deadlines.

A Participant, who separates from service and then returns to service as an Eligible Employee within 30 days, may have the previous election automatically reinstated for the remainder of that Plan Year. If the former Participant returns to service as an Eligible Employee after 30 days, the Employee may make a new election or resume the previous election for the remainder of that Plan Year.

BEFORE YOU DECIDE

Take some time to think about the health care needs of your family. Review last year's preventive care medical, dental, and vision expenses and those from the year before. Then, estimate your out-of-pocket expenses for the upcoming year considering what your medical and/or dental plan(s) cover and what portion you must pay.

If you pay for dependent day care, estimate the amount you expect to pay over the next year. Consider any changes that will occur in dependent day care costs and in the number of eligible dependents you may claim. Remember to take into account such predictable events as family vacations, children entering school, etc.
Cafeteria Plan Reimbursement Accounts should only be used for expenses that you can accurately predict. Ask yourself these questions. . .

Does anyone in my family wear contacts or glasses?
Do my children need orthodontia?
Do I pay for the care of an incapacitated spouse or dependent parent?
Do I have young children who need day care so I can work?
Do I pay a housekeeper to care for my child part of the day?

If you answer YES to any of the above questions, a Cafeteria Plan Reimbursement Account may be right for you. Why not pay your predictable health care and dependent day care expenses with tax-free money?

ABOUT THIS DOCUMENT

This document summarizes the major features of the 125 Cafeteria Plan (Cafeteria Plan). It is recommended that you attempt to refer to the most recent printing of this material occasionally during the plan year. Every effort has been made to make sure this information is clear, easy to understand and accurate. The official plan document contains complete plan provisions and is available for inspection, upon request, through your Employer, or at the Public Employee Health Program Office. In case of any discrepancy between this document and the official plan document, the official plan document will take precedence.

FOR ADDITIONAL INFORMATION

For further clarification of the concepts and rules contained within this document, or if you are experiencing any problem with your Cafeteria Plan accounts, please contact the Public Employees Health Program, FLEX$™ Plan Administration, 560 East 200 South, Suite 110, Salt Lake City, Utah 84102-2004 at (801) 366-7503 or (800) 753-7751.

LIMITED FLEXIBLE SPENDING ACCOUNT PLAN

Prepared for

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

Effective May 1, 2019

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LIMITED FLEXIBLE SPENDING ACCOUNT PLAN
OF GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

ARTICLE 1

1.1 Purpose of Plan. The purpose of the Plan is to provide Eligible Employees of the Employer with the opportunity to choose between taxable Compensation and Qualified Benefits made available under or in conjunction with the Plan. Such Qualified Benefits shall be as described in the Benefit Programs outlined herein, which Benefit Programs are incorporated herein and form part of the Plan.

1.2 Source of Funds. The Plan and Benefit Programs forming part of the Plan shall be funded and maintained by contributions from Participants made pursuant to salary reduction agreement(s) with the Employer as prescribed under the Plan, and by such other contributions of the Employer and Participants to the extent described in a Benefit Program.

1.3 Tax Compliance.

(a) The Plan, and certain or all of the Benefit Programs forming part of the Plan, are intended to result in favorable tax treatment to Participants, Beneficiaries or the Employer, as the case may be. The Plan is therefore intended to comply with any requirements of the Internal Revenue Code (the "Code") and regulations thereunder which impose conditions to such favorable tax treatment. The Plan is specifically intended to qualify as a "Cafeteria Plan" under Section 125 of the Code.

(b) To the extent that any Benefit Program or other feature of the Plan is required to satisfy a standard or other prerequisite to favorable tax treatment, the Plan is intended to facilitate and ensure compliance therewith. Notwithstanding any other terms of the Plan, as with respect to any Benefit Program subject to such prerequisites, the terms of such Benefits Program, including those relating to coverage and Benefits, are hereby intended to be legally enforceable, and each such Benefit Program is intended to be maintained for the exclusive benefit of Eligible Employees.

(c) Each Benefit Program or other component of the Plan may be deemed to be, and shall be treated as, a separate Plan to the extent required or permitted by law, as determined by the Plan Administrator or other legal authority. In the event a Benefit Program, or any portion thereof, is determined to have failed to comply with one or more prerequisites to favorable tax treatment as prescribed under the Code or applicable regulations, that Benefit Program or portion thereof shall be deemed to be and shall be treated as a separate benefit Plan, and the remaining

Benefit Programs, or portions thereof, shall not be affected by such non-compliance.

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

1.4 Effective Date. The provisions of this Plan and of the Benefit Programs forming part of the Plan shall all be effective May 1, 2019.

ARTICLE 2

DEFINITIONS

When used in the Plan, certain terms are capitalized and shall have the respective meanings set forth in this Article or in certain other Articles of the Plan.

Beneficiary. "Beneficiary" means a person who is eligible to receive Benefits under a Benefit Program maintained under the Plan by reason of another individual's active or former service with the Employer.

Benefits. "Benefits" means any amounts paid to a Participant for Qualified Benefits available from time to time under the Plan.

Benefit Program. "Benefit Program" means the Limited Medical Expense Reimbursement Program, the Health Savings Program, and the Dependent Care Assistance Program as set forth in this Plan.

COBRA. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Code. "Code" means the Internal Revenue Code of 1986, as amended from time to time.

Compensation. "Compensation" for any Plan Year means the Compensation paid to the Eligible Employee by the Employer during that period which is currently treated as wages for income tax withholding purposes pursuant to Code Section 3401(a)

(determined without regard to any rules under said Code Section that limit the remuneration included in wages based on the nature or location of the employment or the services performed), plus all other payments of Compensation to the Eligible Employee by the Employer for such period which is not included above, but which is subject to reporting under Code Section 6401(d) and 6051(a)(3), and further including amounts contributed by the Eligible Employee under a salary reduction agreement with the Employer which are excludable from taxable income under Code Section 125, 402(a)(8), 402(h) or 403(b).

Dependent. Except as otherwise provided under the Plan, the term "Dependent" with respect to a Participant (or, if the Participant is married, by the Participant and Spouse) shall have the meaning of that term given by Section 152 of the Code, as amended from time to time.

Dependent Care Assistance Program. The "Dependent Care Assistance Program" is a Benefit Program, the terms and conditions of which are set forth in Article 7.

Eligible Employee. Eligible Employee means any benefit Eligible Employee working for and compensated by Employer who satisfies the eligibility requirements of the Plan as prescribed in Section 3.1.

Employee. For purposes of this document, Employee means an individual who works for the County in an active Employee-Employer relationship; is eligible to participate in any Plan established under this document; and receives wages for employment with GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT.

Employer. "Employer" means GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT.

Enrollment. "Enrollment" shall be the period beginning sixty (60) days prior to the commencement of each Plan Year and ending thirty (30) days prior to the commencement of each Plan Year. In the case of an Employee who first becomes eligible to participate in a Plan after the commencement of a Plan Year, such Employee shall have sixty (60) days following the date the Employee commences work to complete the Salary Reduction Agreement and deliver them to Employer or the Plan Administrator.

Family Status Change. "Family Status Change" means a change in Family Status as defined in Article 4.5 of this Plan.

Health Savings Account. A "Health Savings Account" (HSA) is a tax-exempt trust or custodial account setup to pay or reimburse certain medical expenses.

Health Savings Program. The "Health Savings Program" is a Benefit Program, the terms and conditions of which are set forth in Article 6.

High Deductible Health Plan. A "High Deductible Health Plan" (HDHP) is a health insurance plan with a higher annual deductible than traditional plans and with a maximum limit on out-of-pocket payments for the covered medical expenses.

Highly Compensated Employee. "Highly Compensated Employee" means, with respect to any Plan Year, an Employee of the Employer who meets the definition of highly compensated in Code Section 414(q) and Section 125(b)(1) and (d), as amended from time to time.

Key Employee. A "Key Employee" is any current or former Employee of the Employer (and the Beneficiaries of such Employee) who at any time during the determination period was an Employee that met or meets the definition of a Key Employee in Code Section 416(i)(l), as amended from time to time.

Limited Medical Expense Reimbursement Program. The "Limited Medical Expense Reimbursement Program" is a Benefit Program, the terms and conditions of which are set forth in Article 5.

Participant. A "Participant" is a current Eligible Employee who has elected to participate in the Plan for Plan Year pursuant to the procedures prescribed in Article 4.

Plan. "Plan" means the Limited Flexible Spending Account Plan of Employer, including all Benefit Programs hereunder, and all documents associated with the Plan or any Benefit Program.

Plan Administrator. The "Plan Administrator" is the person, committee, entity or other third party designated under Article 10.1 to serve as administrator and named fiduciary of the Plan. In the absence of such designation, the Employer shall serve as the Plan Administrator.

Plan Year. "Plan Year" means the 12-month period beginning on January 1st and ending on December 31st.

Qualified Benefits. "Qualified Benefits" shall mean a benefit under the Benefit Program(s) described herein.

Qualified Expense. "Qualified Expense" shall mean any amount paid or incurred by a Participant for Qualified Benefits not otherwise reimbursed under any group Plan.

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

Spending Account(s). "Spending Account(s)" shall mean the account(s) established in the Participant's name and which is used to record amounts allocated to a Participant for a Benefit Program and their expenditure for Qualified Benefits.

Spouse. "Spouse" means a person to whom a Participant is legally married. An individual shall be deemed to be a "Spouse" of a Participant as with respect to any expense which is payable or reimbursable under the Plan if that individual is legally married to the Participant at the time the expense is incurred.

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility Requirements. Each Eligible Employee shall be eligible to become a Participant on the first day of employment. To be eligible to enroll in the Limited Flexible Spending Program, an Eligible Employee must enroll in an HDHP and an HSA. An Eligible Employee shall have sixty (60) days following the date the Employee commences work to complete the Salary Reduction Agreement and to deliver the same to Employer's Plan Administrator. If the Plan Administrator does not receive the Salary Reduction Agreement form within sixty (60) days of employment, the Employee shall not be eligible to participate in the Plan until the next Plan Year.

3.2 Cessation of Participation Generally. A Participant shall cease to be a Participant in the Plan as of the earliest of:

(a) the first day of a Plan Year for which the Participant does not elect to participate in any Benefit Program.

(b) the date the Participant ceases to be an Eligible Employee and thereafter fails to make required or voluntary contributions under the Plan; or

(c) the date on which the Plan is terminated.

3.3 Family Medical Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") may revoke his election to participate under any Benefit Program offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall be in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on

FMLA Leave shall have no greater rights to Benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan Participants.

ARTICLE 4

PARTICIPATION ELECTIONS PROCEDURES

4.1 Election Rights. Each Eligible Employee who has satisfied the eligibility requirements of Section 3.1 may elect to participate in any or all of the Benefit Programs made available under the Plan. An Eligible Employee's participation in any Benefit Program shall be subject to the terms and conditions of the Benefit Programs as set forth in the respective Articles of this Plan.

4.2 Effect of Election. For each Plan Year, an Eligible Employee may elect with respect to any Benefit Program to have the Employer reduce a portion of his or her Compensation, and to have such elected amount made available under the Benefit Program to pay for Qualified Expenses incurred by or on behalf of the Eligible Employee and his or her Beneficiaries. An election so made by an Eligible Employee shall constitute the Eligible Employee's Salary Reduction Agreement with the Employer allowing for a reduction in the Eligible Employee's Compensation in an amount equal to the amount to be made available under the Benefit Program to cover Qualified Benefits for and on behalf of the Eligible Employee.

4.3 Election Procedures.

(a) At least sixty (60) days prior to the commencement of each Plan Year, the Plan Administrator shall make available to each Eligible Employee a Salary Reduction Agreement in regard to participation in the Plan for the next Plan Year. In the case of an Employee who first becomes eligible to participate in the Plan after the commencement of a Plan Year, such participation Salary Reduction Agreement shall be made available as prescribed under Section 3.1.

(b) Each Eligible Employee who desires to participate in a Benefit Program for a Plan Year shall so designate such on the Salary Reduction Agreement, and shall further specify the amount of his or her Compensation to be reduced and allocated to each Benefit Program.

(c) A Salary Reduction Agreement must be completed and returned to the Plan Administrator prior to the first day of that Plan Year. If an Eligible Employee fails to deliver a Salary Reduction Agreement to the Plan Administrator prior to the first day of a Plan Year, the Eligible Employee shall not be eligible to participate in any Benefit Program for that Plan Year, except as provided in Article 6.

(d) An Eligible Employee must complete and deliver a Salary Reduction Agreement to the Plan Administrator for each Plan Year for each Benefit Program in which the Eligible Employee desires to participate, except as provided in Article 6.

4.4 Irrevocable Status of Elections. Except as otherwise provided in this Article 4 and in Article 6, any election made or deemed to have been made by this Article 4, any election made or deemed to have been made by an Eligible Employee with regard to participating or declining to participate in any Benefit Program offered within the Plan and with respect to any Plan Year shall be irrevocable for the duration of that Plan Year. During Family Medical Leave, a participant may exercise whatever rights such Participant has under the Family Medical Leave Act and regulations promulgated thereunder as more fully set forth in Article 3.3.

4.5 Changes in Family Status Rules.

(a) Notwithstanding Section 4.4 above, a Participant may revoke the Salary Reduction Agreement with respect to a Benefit Program in effect for a Plan Year or, alternatively, may modify a prior election to take effect for the remainder of the Plan Year, the revocation and the new election or modification, as the case may be, is on account of and consistent with a change in family status. In this regard, a benefit election revocation or modification shall be deemed to be consistent with a Family Status Change only if the revocation or modification is necessary or appropriate as a result of the Family Status Change.

(b) For purposes of subsection (a) above, a “change in family status” as with respect to a Participant shall include the following:

(i) the marriage, divorce or legal separation of the Participant;

(ii) the death of the Participant’s Spouse or Dependent;

(iii) the birth or adoption of a child of the Participant;

(iv) the commencement or termination of employment of the Participant’s Spouse;

(v) a change from part-time to full-time employment status (or vice versa) by the Participant or the Participant’s Spouse;

(vi) the taking of an approved unpaid leave of absence by the Participant or the Participant’s Spouse which leave shall include entering into or returning from “uniformed service” as defined

under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA); or the occurrence of a special Enrollment period as defined in Section 9801(f) of the Code); or

(vii) such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) Any new election made under subsection (a) above shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the Family Status Change form is completed and returned to the Plan Administrator or its delegate. Family Status Changes must be made within sixty (60) days of when the event occurred. If the Family Status Change form is not received by the Plan Administrator within sixty (60) days of the change in family status, the Family Status Change form shall be invalid.

4.6 Effect of Separation From Service.

(a) Except as specifically provided under the Plan, a Participant who separates from service during a Plan Year may revoke all existing benefit elections and terminate the entitlement to the reimbursement of expenses incurred during the Plan Year after the separation of service, except as provided in Article 6.

(b) To the extent required or permitted under the Plan, a Participant who separates from service may elect to continue to make contributions to the Plan to provide for the funding of Benefits for the remainder of that Plan Year, except as provided in Article 6. If such a Participant fails to timely make any required contributions, the Participant shall not be entitled to reimbursements under the Plan.

(c) However, nothing in this Article 4.6 shall prohibit the payment of Benefits for Qualified Expenses with respect to claims arising prior to the Participant's termination of participation. Also, a former Participant who continues to receive Compensation from the Employer and for whom payroll deductions continue to be made shall remain a Participant for all purposes until such Compensation ceases.

(d) Moreover, a terminated Participant shall be entitled to reimbursement of claims for Qualified Expenses incurred prior to his or her termination of employment, but only if the Participant (or his or her estate) applies for such reimbursement on or before ninety (90) days following the Participant's termination of participation or ninety (90) days following the close of the Plan Year, whichever is applicable, except as provided in Article 6.

(e) A Participant whose benefit election(s) for a Plan Year are revoked under either subsection (a) or (b) above shall not be entitled to make any new benefit elections in regard to the remaining portion of that Plan Year of separation, even if the Participant returns to service before the end of that Plan Year. However, a former Participant who returns to service as an Eligible Employee may make a new benefit election for a Plan Year succeeding the Plan Year of the Participant's prior separation from service pursuant to the general rules prescribed in Article 4.3 and 3.1.

4.7 Payment of Contributions While on FMLA Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 ("FMLA Leave") and who elects to continue participation under this Plan shall be responsible for making the required contributions under the Limited Medical Expense Reimbursement Program offered under this Plan during the period of the FMLA Leave. The manner in which such payments are made shall be determined by the Employer in its sole discretion, among the following alternatives:

(a) Prepayment: The Participant may prepay the contributions due during the FMLA Leave period. Prepayment may not be required as a condition to remaining in the Plan, and prepayment may not be the sole option of making contributions hereunder.

(b) Pay-As-You-Go: The contributions due during the FMLA Leave period may be paid based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as COBRA payments are made, under the Employer's existing rules for payment by Employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant.

(c) Catch-Up Option: The Employer may advance the contributions on behalf of the Participant, and may recoup such contributions upon the Participant's return to employment. The "Catch-Up Option" shall be applied in a manner consistent with Prop. Treas. Reg. Sec. 1.125-3.

Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law. The Prepayment Option and Catch-up Option may not be offered without also offering the Pay-As-You-Go Option.

4.8 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue

participation in the Plan. The coverage period shall be in accordance with USERRA § 4317 as amended from time to time. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Employer in a manner similar to Article 4.7 (regarding the payment of contributions with respect to FMLA Leave). A 2% administrative fee may be charged in accordance with USERRA. A Participant whose coverage under the Limited Medical Expense Reimbursement Program is terminated on account of his or her being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such Plan, provided that such requirement would not have been imposed if coverage had not been terminated as a result of "uniformed service."

4.9 Changes by a Plan Administrator. The Plan Administrator may adopt such rules and take such actions as it deems necessary or desirable to assure that the various statutory or other limitations on Benefits provided to prescribed classes of Participant are satisfied. Such action may include a modification of any election made by a Participant as to the amount of salary reduction contributions to be made by the Participant under the Plan during a Plan Year.

ARTICLE 5

LIMITED MEDICAL EXPENSE REIMBURSEMENT PROGRAM

5.1 Purpose of Program. The Purpose of the Limited Medical Expense Reimbursement Program as described in this Article 5 is to provide Eligible Employees with the opportunity to elect for each Plan Year to have a portion of their taxable Compensation reduced, and to have such elected amount allocated and made available to reimburse them for Qualified Medical Expenses incurred during such Plan Year which are not payable or reimbursable under a Group Medical Plan, or from any other Plan or source.

5.2 Status as Accident or Health Plan. It is the intention of the Employer that the Limited Medical Expense Reimbursement Program qualify as an "accident or health Plan" within the meaning of Section 105(e) of the Code, and that Benefits provided under the Limited Medical Expense Reimbursement Program to or on behalf of Eligible Employees, or their Spouses or Dependents, be eligible for exclusion from their gross income pursuant to Sections 105(b), 106 and 125 of the Code.

5.3 Enrollment in Program. Each Eligible Employee may elect to enroll in the Limited Medical Expense Reimbursement Program for a Plan Year pursuant to the procedures set forth in Section 4.3 and 3.1. Such election shall specify the amount of the Compensation for that Plan Year which the Eligible Employee

directs to have reduced and made available for reimbursement of Qualified Medical Expenses during that Plan Year.

5.4 Maximum Annual Benefits. The maximum amount of Compensation which an Eligible Employee may elect to have reduced and set aside on the Eligible Employee's behalf under the Limited Medical Expense Reimbursement Program for Plan Year, and thus the maximum amount of reimbursements which may be made to the Eligible Employee for Qualified Medical Expenses incurred during the Plan Year is $2,700.

5.5 Spending Accounts. The Plan Administrator shall establish a separate Limited Medical Expense Spending Account for each Eligible Employee who elects to participate in the Limited Medical Expense Reimbursement Program for a Plan Year. Such Spending Account shall be credited with the salary reduction contribution which the Eligible Employee has elected to have set aside for the Plan Year under the Limited Medical Expense Reimbursement Program, and shall be charged with all reimbursements and any administrative expenses made from or assessed against such Spending Account for that Plan Year.

5.6 Conditions to Reimbursement. A Participant shall be entitled to a reimbursement from his or her Limited Medical Expense Spending Account for a Plan Year only if the following conditions are satisfied:

(a) The expense to which the reimbursement relates is a Qualified Medical Expense as defined in Section 5.7 below;

(b) Such expense was incurred during that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant was enrolled in the Limited Medical Expense Reimbursement Program; and

(c) The Participant has complied with the Expense Reimbursement procedures prescribed under Article 8.

5.7 Qualified Medical Expenses. A "Qualified Medical Expense" with respect to a Participant means an expense incurred for the medical care, as defined in Section 213 of the Code. For purposes of this Limited Medical Expense Spending Account, "Qualified Medical Expenses" shall further be limited to dental, vision, and preventive care of the Participant, or for the Spouse or Dependent of the Participant, and not reimbursable under any other plan.

For purposes of establishing the status of an expense as a Qualified Medical Expense, the term "Dependent" as with respect to a Participant is defined in Article 2. In addition, and solely for purposes of this Limited Medical Expense Reimbursement Program, a child of a divorced Participant shall be treated as a

Dependent of the Participant for a Plan Year if more than one-half of the child's support for the year is provided by the Participant. Such status shall exist even if the Participant is not the custodial parent with respect to the child or is otherwise not eligible to claim a personal exemption deduction with respect to such child for income tax purposes.

5.8 Timing of Expense Incurrence. A Qualified Medical Expense is reimbursable from a Participant's Medical Expense Spending Account for a Plan Year only if such expense is incurred during that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant is enrolled in the Limited Medical Expense Reimbursement Program. In this regard, an expense is deemed to have been incurred by a Participant on the date the Participant or Beneficiary is provided with medical care that gives rise to the expense, and not when the Participant or individual is billed, charged for or pays for the medical care. Accordingly, an otherwise Qualified Medical Expense is not reimbursable from a Participant's Limited Medical Expense Spending Account if such expense was incurred prior to the date on which the Participant enrolled in the Limited Medical Expense Reimbursement Program. Similarly, reimbursements may not be made from a Participant's Limited Medical Expense Spending Account for any Plan Year as with respect to any expense incurred prior to the Plan Year or after the 15th day of the third calendar month immediately following the Plan Year. However, reimbursements of Qualified Medical Expenses incurred during a Plan Year may be made after the end of the Plan Year as set forth in Section 7.2, 7.3 and 7.4.

5.9 Uniform Availability of Benefit. A Participant who elects to participate in the Limited Medical Expense Reimbursement Program for a Plan Year shall be entitled at all times during that Plan Year to reimbursements from the Limited Medical Expense Spending Account. The amount of reimbursements to which the Participant is entitled as of any date is an amount equal to the total annual benefit elected by the Participant pursuant to Section 5.4 (or, if the Participant has modified such elected benefit amount, equal to the modified amount), reduced by any prior reimbursement or expenses charged to such Spending Account for that Plan Year. Such right to reimbursement as of any date shall be without regard to the amount of the Participant's Compensation which has been reduced and allocated to the Participant's Limited Medical Expense Spending Account as of that date.

5.10 State Medicaid Benefits Rights. Notwithstanding any provision of the Plan to the contrary, the following rules shall apply.

(a) Payment for Benefits with respect to a Participant under the Limited Medical Expense Reimbursement Program shall be made in accordance with any assignment of rights made by or on behalf of such Participant, or a Beneficiary of the Participant, as required by a State Medicaid Plan.

(b) The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's Enrollment as a Participant or Beneficiary in the Limited Medical Expense Reimbursement Program, or in determining or making any payments for Benefits of the individual as a Participant or Beneficiary in the Limited Medical Expense Reimbursement Program.

(c) Payments for Benefits under the Limited Medical Expense Reimbursement Program shall be made to a State in accordance with any State law which provides that the State has acquired the rights with respect to a Participant for items or services constituting medical assistance under a State Medicaid Plan.

(d) For purposes of this Section 5.10, a "State Medicaid Plan" means a State Plan for medical assistance approved under Title XIX of the Social Security Act.

ARTICLE 6

HEALTH SAVINGS PROGRAM

6.1 Purpose of Program. The Purpose of the Health Savings Program as described in this Article 6 is to provide Eligible Employees with the opportunity to elect to have a portion of their taxable Compensation reduced, and to have such elected amount contributed to the Eligible Employee's HSA, to be used as permitted by the Code and regulations thereunder.

6.2 Status as Accident or Health Plan. It is the intention of the Employer that the Health Savings Program qualify as an "accident or health Plan" within the meaning of Section 105(e) of the Code, and that Benefits provided under the Health Savings Program to or on behalf of Eligible Employees, or their Spouses or Dependents, be eligible for exclusion from their gross income pursuant to Sections 105(b), 106 and 125 of the Code.

6.3 Enrollment in Program. Each Eligible Employee may elect to enroll in the Health Savings Program if they have enrolled in a HDHP, are an "eligible individual" as defined in Section 223(c)(1)(A) to make contribution to an HSA, and have established an HSA. Such election shall specify the amount of the Compensation which the Eligible Employee directs to have reduced and contributed to the HSA.

6.4 Maximum Contributions. Total contributions to an HSA are limited by IRS regulations. The Eligible Employee is responsible for monitoring the contributions to their HSA. The Eligible Employee may adjust the salary

reduction contributions prospectively from month to month, initiating, increasing, decreasing, or terminating future contributions. All contributions shall be made to the HSA Trustee or its representative.

6.5 HSA Accounts. The Plan Administrator shall establish a separate HSA Account for each Eligible Employee who elects to participate in the Health Savings Program. The Plan Administrator shall coordinate with the HSA Trustee to make the HSA account balance, (all contributions and earnings less fees and disbursements), available to the participant for disbursement through such means as designated by the Plan Administrator.

6.6 Conditions to Disbursement. A Participant shall be entitled to a disbursement from his or her HSA Account upon request.

6.7 Availability of Benefit. A Participant who elects to participate in the Health Savings Program shall be entitled to disbursement of funds from his or her HSA Account up to the balance of that account at the time the request is processed.

6.8 State Medicaid Benefits Rights. Notwithstanding any provision of the Plan to the contrary, the following rules shall apply.

(a) Payment for Benefits with respect to a Participant under the Health Savings Program shall be made in accordance with any assignment of rights made by or on behalf of such Participant, or a Beneficiary of the Participant, as required by a State Medicaid Plan.

(b) The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's Enrollment as a Participant or Beneficiary in the Health Savings Program, or in determining or making any payments for Benefits of the individual as a Participant or Beneficiary in the Health Savings Program.

(c) Payments for Benefits under the Health Savings Program shall be made to a State in accordance with any State law which provides that the State has acquired the rights with respect to a Participant for items or services constituting medical assistance under a State Medicaid Plan.

(d) For purposes of this Section 6.8, a "State Medicaid Plan" means a State Plan for medical assistance approved under Title XIX of the Social Security Act.

ARTICLE 7

DEPENDENT CARE ASSISTANCE PROGRAM

7.1 Purpose of Program. The purpose of the Dependent Care Assistance Program as described in this Article 7 is to provide Eligible Employees with the opportunity to elect for each Plan Year to have a portion of their taxable Compensation reduced, and to have such elected amount allocated and made available to reimburse them for Qualified Dependent Care Expenses incurred during such Plan Year which are not payable or reimbursable from any other Plan or source.

7.2 Status as Dependent Care Assistance Program. It is the intention of the Employer that the Dependent Care Assistance Program qualify as a "Dependent Care Assistance Program" within the meaning of Section 129(d) of the Code, and that reimbursements provided under the Dependent Care Assistance Program to Participants be eligible for exclusion from their gross income pursuant to Section 129(a) of the Code.

7.3 Enrollment in the Program. The Plan Administrator shall provide each Eligible Employee with a written notice of the availability of the Dependent Care Assistance Program including the terms and conditions of participation. An Eligible Employee may thereupon elect to enroll in the Dependent Care Assistance Program for a Plan Year pursuant to the procedures prescribed in Section 4.3. Such election shall specify the amount of the Compensation for that Plan Year which the Eligible Employee directs to have reduced and made available for the reimbursement of Qualified Dependent Care Expenses incurred during that Plan Year.

7.4 Maximum Annual Benefits.

(a) Subject to subsection (b) below, the maximum amount of Compensation which a Participant may elect to have reduced and set aside on a Participant's behalf under the Dependent Care Assistance Program for a Plan Year, and thus the maximum amount of reimbursements which may be made to the Participant for Qualified Dependent Care Expenses incurred during the Plan Year, is $5,000.

(b) Notwithstanding subsection (a) above, the maximum annual benefit which a Participant may elect for a Plan Year shall be limited to the least of the amounts set forth below:

(i) $2,500 in the case of a married Participant if the Participant and the Participant's Spouse will file a separate federal income tax return for the tax year which coincides with such Plan Year;

(ii) the total taxable Compensation and other earned income of the Participant from the Employer, for that Plan Year; and

(iii) in the case of a married Participant, the total taxable Compensation and other earned income of the Participant's Spouse for that Plan Year;

(iv) the amount Participant elects to set forth pursuant to Article 7.3 above.

Notwithstanding the foregoing, the additional limitations prescribed above shall be imposed with respect to an Eligible Employee for a Plan Year only if at the time of the Eligible Employee's election the Plan Administrator knows or has reason to know that the circumstances giving rise to such limitation in fact exist or will exist with respect to the Eligible Employee for that Plan Year.

(c) For purposes of subsections (b)(ii) and (iii) above, a Participant shall be deemed to be married with respect to a Plan Year if the Participant is so married to a Spouse on the last day of that Plan Year.

(d) For purposes of subsection (b)(iii) above, the Spouse of a married Participant shall be deemed to have earned income for any month during a Plan Year in which such Spouse is either physically or mentally incapable of self-care, or is a full-time student during at least five (5) calendar months during that Plan Year. The amount of such deemed earned income for each such month is $200 if the Participant has one Qualifying Individual (as defined in Section 7.7 below), and $400 per month if the Participant has more than one Qualifying Individual.

(e) The Plan Administrator may, in its sole discretion, secure from an Eligible Employee such information as may be appropriate to determine whether any of the special limitations prescribed in subsection (b) above may be applicable to the Eligible Employee for a Plan Year.

7.5 Spending Accounts. The Plan Administrator shall establish a separate Dependent Care Spending Account for each Eligible Employee who elects to participate in the Dependent Care Assistance Program for a Plan Year. Such Spending Account shall be credited with the salary reduction contributions which the Eligible Employee has elected to have set aside for the Plan Year under the Dependent Care Assistance Program, and shall be charged with all reimbursements and any administrative expenses made from or assessed against such Spending Account for that Plan Year.

7.6 Conditions to Reimbursement. A Participant shall be entitled to a reimbursement from the Dependent Care Spending Account for a Plan Year only if the following conditions are satisfied:

(a) The Participant has one or more Qualifying Individuals, as defined in Section 7.7 below, with respect to such Plan Year;

(b) The expense to which the reimbursement request relates is a Qualified Dependent Care Expense as defined in Section 7.8 below;

(c) The expense to which the reimbursement request relates was incurred (as defined in Section 7.9 below) during that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant was enrolled in the Dependent Care Assistance Program; and

(d) The Participant has complied with the expense reimbursement procedures prescribed under Article 8.

7.7 Qualifying Individuals. For purposes of this Article 7, a person is a "Qualifying Individual" with respect to a Participant as of any date if as of such date such person is:

(a) a Dependent of the Participant under the age of 13 with respect to whom the Participant is entitled to a personal exemption deduction for income tax purposes; or

(b) a Dependent or Spouse of the Participant who is physically or mentally incapable of self-care.

7.8 Qualified Dependent Care Expenses.

(a) Except as may otherwise be provided below, a "Qualified Dependent Care Expense" with respect to a Participant means an expense for Dependent care which is incurred to enable the Participant to be gainfully employed during a period for which there are one or more Qualifying Individuals with respect to the Participant.

(b) Notwithstanding the foregoing, the following expenses shall not be deemed "Qualified Dependent Care Expenses," and thus shall not be reimbursable under the Dependent Care Assistance Program, these expenses include, but are not limited to:

(i) Any expense associated with providing Dependent care to a Participant's Dependent or Spouse who is a Qualifying Individual by reason of being incapable of self-care, if the Plan Administrator knows or has reason to know such person does not regularly spend at least eight (8) hours each day in the Participant's home.

(ii) Any expense for services provided by a day care center if the Plan Administrator knows or has reason to know that such center either does not comply with all applicable state and local laws and regulations, or does not provide care to more than six (6) individuals on a regular basis during the Plan Year.

(iii) Any expense which the Plan Administrator knows or has reason to know represents the cost of sending a child to an overnight camp.

(iv) Any expense which the Plan Administrator knows or has reason to know represents an amount paid to any individual who is:

(A) A Dependent of the Participant with respect to when the Participant can claim a personal exemption deduction for income tax purposes;

(B) the Spouse of the Participant; or

(C) a child of the Participant who is under the Age of 19 as of the last day of the Plan Year.

(v) Any expense which the Plan Administrator knows or has reason to know has been paid or is reimbursable under any other program or from any source (other than this Plan).

(vi) Any expense that is excluded by federal regulations including but not limited to food, clothing, or educational services unless these services are minimal or insignificant and inseparable from the portion of the expense that is for care, or for the individual's well being and protection.

(c) For purposes of establishing the status of an expense as a Qualified Dependent Care Expense, the term "Dependent" with respect to a Participant is as defined in Article 2; except that a child of a divorced Participant shall be treated as a Dependent of the Participant for a Plan Year only if the Participant has custody of the child for a longer period during the Plan Year than the other parent. Such status shall exist even if the Participant is not otherwise eligible to claim a dependency exemption deduction with respect to such child for income tax purposes by reason of a written release to such exemption claim made under Code Section 152(e).

7.9 Timing of Expense Incurrence. A Qualified Dependent Care Expense is reimbursable from a Participant's Dependent Care Spending Account for a Plan Year only if such expense is incurred during the Plan Year or during the two

and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant is enrolled in the Dependent Care Assistance Program. In this regard, an expense is deemed to have been incurred by an individual on the date on which the Qualifying Individual to whom the expense relates is provided with the Dependent care that gives rise to the expense, and not when the Participant or Qualifying Individual is billed, charged for or pays for the Dependent care. Accordingly, an otherwise Qualified Dependent Care Expense is not reimbursable from a Participant's Dependent Care Spending Account if such expense was incurred prior to the date on which the Participant enrolled in the Dependent Care Assistance Program. Similarly, reimbursements may not be made from a Participant's Dependent Care Spending Account as with respect to any expense incurred prior to the Plan Year or after the 15th day of the third calendar month immediately following the Plan Year. However, reimbursements of Qualified Dependent Care Expenses incurred during a Plan Year may be made after the end of the Plan Year as prescribed in Article 8.

7.10 Limited Availability of Benefits. The amount to which a Participant is entitled as a reimbursement under the Dependent Care Spending Account as of any date during a Plan Year is limited to the total amount of the Participant's elective contributions made to such account for the Plan Year as of such date, reduced by any prior reimbursements and administrative expenses charged to that account for that Plan Year.

7.11 Plan Administrator Rules. The Plan Administrator may adopt such rules as it deems necessary or desirable to impose limitations on the amount of contributions elected to be made by Participants under the Dependent Care Assistance Program for the purpose of assuring that the limitations prescribed under this Article 7 are satisfied.

7.12 Annual Benefit Statement. The Plan Administrator or Employer shall provide to each Participant receiving reimbursements from the Dependent Care Assistance Program during a calendar year a written statement setting forth the amounts reimbursed or to be reimbursed to the Participant for such year. Such written statement shall be provided on or before January 31 following the end of the calendar year at issue. In lieu of a separate written statement, the information may be included in the Participant's Form W-2, Wage and Tax Statement, for such year. If as the time such annual benefit statement is being prepared, the Plan Administrator is unable to ascertain the total amount of reimbursement which will be made to a Participant for the year, the Plan Administrator may report in the annual benefit statement a reasonable estimate of the total amount of reimbursements. In this regard, the amount of Compensation which the Participant elected to have set aside under the Dependent Care Assistance Program for the year shall be deemed to be a reasonable estimate of the total amount to be reimbursed to the Participant for the year.

ARTICLE 8

EXPENSE REIMBURSEMENT PROCEDURES

8.1 **General Rules**. Reimbursement of Qualified Expenses under the Plan shall be made to a Participant upon the filing of a prior request for such reimbursement with the Plan Administrator or its delegate. Any such request shall not be acted upon unless it is (i) made on such form as the Plan Administrator may make available for such purpose, (ii) signed by the requesting Participant; and (iii) timely filed with the Plan Administrator or its delegate. All requests for reimbursement under the Plan shall be subject to, and shall be processed in accordance with, the procedures set forth in this Article 8 and such other procedures prescribed from time to time by the Plan Administrator. All such procedures shall be uniformly applied to similarly situated Participants.

8.2 **Timing of Requests**. In all events, requests for reimbursement under the Plan must be submitted within ninety (90) days following the end of the Plan Year. Any request for a reimbursement with respect to a Plan Year which is received after the foregoing deadline is ineligible for reimbursement.

8.3 **Forfeitures**. If the total Qualified Expenses paid or reimbursed to a Participant with respect to any Plan Year for the Limited Medical Expense Reimbursement Program or the Dependent Care Assistance Program are less than the amount set aside for reimbursement by the Participant in any Plan Year, the unused portion shall be forfeited ninety (90) days following an Employee's date of termination from plan participation or ninety (90) days after the end of the Plan Year, whichever is earlier. No Participant shall be entitled to carry over any unused dollar amounts for either of these two Benefit Programs to the succeeding Plan Year or to reallocate the unused portion to any other Benefit Program, nor shall any Participant be entitled to receive any unused portion in the form of cash.

8.4 **Reimbursements**. Except as provided in any Plan, contract or arrangement established to provide Benefits, reimbursement of Qualified Expenses shall be made at such time and in such amounts as shall be determined by Employer or the Plan Administrator in accordance with law. Except as provide in Article 6, the amounts set aside under a Participant's Salary Reduction Agreement for any Plan Year shall be used only to reimburse the Participant for Qualified Expenses incurred for such Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year, and only if the Participant applies for reimbursement on or before the dates set forth in Article 7.2 and 7.3 above.

8.5 **Minimum Reimbursements**. At the discretion of the Plan Administrator, a request by a Participant for a reimbursement under either the Limited Medical

Expenses Reimbursement Program or the Dependent Care Assistance Program shall be accepted and acted upon if the amount of the request is for at least $50.00 (or, if less, the remaining balance of the Participant's account). The foregoing restriction shall not apply, however, to the final reimbursement to be made to a Participant for a Plan Year.

8.6 Claims Substantiation. No expense reimbursement shall be made to a Participant under the Limited Medical Expense Reimbursement Program or the Dependent Care Assistance Program unless the expense is documented directly by the Administrator or the Participant:

(a) provides an invoice or other written statement from the service provider or other applicable independent third party which evidences that the expense has been incurred and the amount of such expense; and

(b) attests in writing that the expense at issue has not been reimbursed and is not reimbursable under any other Plan.

8.7 Processing Fee. The Plan Administrator may impose upon a Participant a reasonable fee for the processing of a reimbursement under the Plan. Any such fee shall be charged to the Spending Account of the Participant from which such reimbursement is made.

8.8 Nondiscrimination. Notwithstanding any provision of the Plan to the contrary, in no event shall the aggregate amount of reimbursements or other Benefits provided to Key Employees under the Plan for a Plan Year exceed twenty-five percent (25%) of the aggregate amount of such reimbursements or other Benefits provided to all Participants for such Plan Year. The Plan Administrator may adopt such rules as it deems necessary or desirable to assure that the foregoing limitation is satisfied, including imposing restrictions on the amount of contributions which a Key Employee may elect to have set aside under the Plan for a Plan Year. Any such rules shall be uniformly applied to similarly situated individuals.

8.9 Appeals Procedures.

(a) Any Participant or other person who believes that a benefit is due to such person under the Plan, including one greater than that initially determined by the Plan Administrator, may file an appeal in writing with the Plan Administrator.

(b) The Plan Administrator shall within ninety (90) days of the receipt of an appeal either allow or deny the claim in writing. A denial of an appeal shall be written in a manner calculated to be understood by the claimant and shall include:

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

(ii) specific references to pertinent Plan provisions on which the denial is based;

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

(iv) an explanation of the Plan's claim review procedure.

(c) A claimant whose claim is denied (or the claimant's duly authorized representative) may, within sixty (60) days after receipt of the claim denial:

(i) submit a written request for review to the Plan Administrator;

(ii) review pertinent documents; and

(iii) submit issues and comments in writing.

(d) The Plan Administrator shall notify the claimant of its decision on review within sixty (60) days of receipt of a request for review. The decision on review 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 provision on which the decision is based.

(e) The 90-day and 60-day periods described in subsections (b) and (d), respectively, may be extended at the discretion of the Plan Administrator for a second ninety (90) and sixty (60) day period, as the case may be, provided that written notice of the extension is furnished to the claimant prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected.

(f) A claimant may state the reason or reasons forming the basis of the claim to a benefit under the Plan, and may submit written evidence in support of the claim made under and in accordance with the procedures set forth in this Section 7.9. Such action is not required. However, the failure to state a reason or to submit written evidence in support of a claim shall permanently bar the claimant from raising such reason or submitting such evidence in any forum at a later date.

(g) Participants and Beneficiaries shall not be entitled to challenge the Plan Administrator's determinations in judicial or administrative proceedings

without first complying with the procedures in this Article. The decisions made pursuant to this Section are intended to be final and binding on Participants, Beneficiaries and others.

(h) Notwithstanding the other sections of this Article 7, if the Public Employees Health Program (PEHP) is the Plan Administrator, the procedure for appealing denied claims shall be administered in accordance with Utah Code Ann. § 49-11-613 as amended.

ARTICLE 9

COBRA CONTINUATION RIGHTS

9.1 In General. Any Participant and/or Dependent who experiences a Qualifying Event with respect to the Limited Medical Expense Reimbursement Program shall thereafter be eligible for Benefits under the Limited Medical Expense Reimbursement Program in such amounts and for such periods as may be mandated under the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and this Article 9.

9.2 Continuation of Coverage. To the extent required by Section 9.1 above, a Qualified Beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

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

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

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

(a) in the case of a terminated Participant or a Participant whose hours have been reduced, except as provided in (b) and (c) below, and his or her covered Dependents, the date which is 18 months after the qualifying event;

(b) in the case of a Qualified Beneficiary disabled during the first sixty (60) days following the covered Participant's termination the date which is 29 months after the qualifying event, provided the Qualified Beneficiary provides the Plan Administrator with notice of Social Security disability determination within sixty (60) days of the disability determination and within 18 months of the qualifying event;

(c) in the case of a qualifying event which occurs during the 18 months after the date that a Participant is terminated or the date that a Participant's hours are reduced, for the covered Dependents, the date which is 36 months after the date that a Participant is terminated, or the date that a covered Participant's hours are reduced;

(d) for Plan Years commencing on or prior to June 30, 1997, in the case of a termination or reduction in hours of a Participant and that Participant's subsequent entitlement to Medicare while continuation coverage is in force for the Qualified Beneficiary, the date which is 36 months after the date of the Participant's entitlement to Medicare;

(e) in the case of any qualifying event except as described in (a), (b), (c) and (d) above, the date which is 36 months after the date of the qualifying event;

(f) the date on which Employer ceases to provide any flexible spending Plan to any Employee;

(g) the date on which the Qualified Beneficiary fails to make timely payment of the required contribution pursuant to this provision;

(h) the date on which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health Plan as an Employee or Dependent, or otherwise becomes entitled to Benefits under Title XVIII of the Social Security Act (Medicare).

9.5 Contribution.

(a) A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable contribution required under the Plan in full and in advance, except as provided in (b) below. Such contribution shall not exceed the requirements of

applicable federal law. A Qualified Beneficiary may elect to pay such contribution in monthly installments.

(b) Except as provided in (c) below, the payment of any contribution shall be considered to be timely if made within thirty (30) days after the date due, or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) and (b) above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required contribution for continuation coverage during the period preceding the election to be made within 45 days of the date of the election..

(d) A 2% administrative fee may be charged in accordance with COBRA.

9.6 Notification by Qualified Beneficiary. Each Participant or Qualified Beneficiary must notify the Plan Administrator or the Employer of the occurrence of a divorce or legal separation of the Participant from such covered Participant's Spouse, and/or the Participant's Dependent child ceasing to be a Dependent child under the terms of this Plan within sixty (60) days after the date of such occurrence.

9.7 Notification to Qualified Beneficiary.

(a) Upon receipt of written notice of a Qualifying Event the Plan Administrator shall then provide written notice to each Qualified Beneficiary of his or her right to continuation coverage under this provision as required by federal law.

(b) The Plan Administrator shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the Participant from the Participant's Spouse or a Dependent child ceasing to be a Dependent child under the terms of this Plan, the administrator shall only be required to notify a Qualified Beneficiary of his or her right to elect continuation coverage if the Qualified Beneficiary notifies the Administrator of such qualifying event occurring within sixty (60) days after the date of such qualifying event.

(c) Notification of the requirements of this provision to the Spouse of a Participant shall be treated as notification to all other qualified Beneficiaries residing with such Spouse at the time notification is made.

9.8 Definitions. The terms used in the text of this Article 8 are defined as follows:

(a) "Dependents" for the purposes of the Limited Medical Reimbursement Plan, include individuals who are Dependents within the meaning of section 152(a) of the Code.

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

If both an Employee and an Employee's Spouse are employed by Employer, Dependent children may be covered by either Spouse, but not by both.

(b) "Election Period" means the 60-day period during which a Qualified Beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than sixty (60) days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

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

(d) "Medicare" means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

(e) "Qualified Beneficiary" means an individual who, on the day before the qualifying event for a Participant, is a Beneficiary under this Plan as the Spouse or Dependent child of the Participant. In the case of the termination of a Participant or the reduction in hours of the Participant's employment, the term Qualified Beneficiary, includes the Participant. A child who is born to (or placed for adoption with) a Qualified Beneficiary who is a Participant during the Coverage Period shall also be a Qualified Beneficiary.

Exception – the term Qualified Beneficiary does not include an individual whose status as a Participant is attributable to a period in which such individual is a nonresident alien who received no earned income from the Employer which constituted income from sources within the United States (within the meaning of code Section 911(d)(2) and Section 861(a)(3)). If an individual is not a Qualified Beneficiary pursuant to this

paragraph, a Spouse or Dependent child of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to such individual.

(f) "Qualifying Event" means with respect to a Participant, an of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a Qualified Beneficiary:

(i) the death of the Participant;

(ii) the termination (except by reason of such Participant's gross misconduct) or reduction in hours of the Participant's employment;

(iii) the divorce or legal separation of the Participant from such Participant's Spouse;

(iv) the Participant becoming entitled to Benefits under Title XVIII of the Social Security Act (Medicare);

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

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

ARTICLE 10

ADMINISTRATION OF THE PLAN

10.1 Plan Administrator. The Employer, acting through the Department of Human Resource Management, may appoint a person, a committee consisting of more than one person, an entity, or other third party to serve as the Plan Administrator and named fiduciary of the Plan. In the absence of such an appointment, the Employer shall serve as such Plan Administrator and named fiduciary.

10.2 Powers and Duties of Plan Administrator. Except as specifically provided otherwise, the Plan Administrator shall have final and binding discretionary authority to control and manage the operation and administration of the Plan, including all rights and powers necessary or convenient to the carrying out of its functions hereunder, whether or not such rights and powers are specifically enumerated herein. In exercising its responsibilities hereunder, the Plan Administrator may manage and administer the Plan through the use of agents (who may include Employees of the Employer). Without limiting the generality

of the foregoing, and in addition to the other powers set forth in this Article 10, the Plan Administrator shall have the following express authorities:

(a) To construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any Benefits hereunder, all in the sole discretion of the Plan Administrator. Any such construction, interpretation, etc., shall be final and binding on Participants, Beneficiaries and all other persons.

(b) To prescribe procedures to be followed by Participants in filing requests for reimbursements of proper expenses, and to authorize payment of such expense reimbursements.

(c) To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan.

(d) To receive from the Employer, and from Participants and Beneficiaries, such information, and to maintain records concerning such information, as shall be necessary for the proper administration of the Plan.

(e) To furnish the Employer upon request such annual and other reports with respect to the administration of the Plan as are reasonable and appropriate.

(f) To review and decide claims for Benefits, and the review of the denial of any such claims, pursuant to and to the extent provided in Section 8.9, including any interpretations of the Plan, which decisions and interpretations the Plan Administrator shall have full discretion and authority to make hereunder.

10.3 Consultation with Advisors. Except as specifically provided herein, the Plan Administrator (or any other fiduciary designated pursuant to Section 10.5) may employ one or more persons to render advice with regard to any responsibility it may have under the Plan. The Plan Administrator may consult with counsel, actuaries, accountants, physicians or other advisors (who may be counsel, actuaries, accountants, physicians or other advisors for the Employer) and may also from time to time utilize the services of Employees and agents of the Employer in the discharge of its responsibilities.

10.4 Records and Reports. The Plan Administrator shall take all such action as it deems necessary or appropriate to comply with governmental laws and regulations relating to the maintenance of records, notifications to Participants, filings with the Internal Revenue Service and U.S. Department of Labor, and all other such requirements applicable to the Plan. Employer shall be responsible for preparing and filing a Form 5500 with the Internal Revenue Service.

10.5 Designation of Other Fiduciaries. The Employer, acting through the Department of Human Resource Management, may designate in writing other persons to carry out a specified part or parts of the Plan Administrator's responsibilities hereunder (including the power to designate other persons to carry out a pat of such designated responsibility); provided, however, that such designation may not include any power to manage or control assets of the Plan, or to amend the Plan. Any such designation must be accepted by the designated person, who shall acknowledge in writing that such person is a fiduciary with respect to the Plan.

10.6 Obligations of Plan Administrator and Employers.

(a) The Plan Administrator shall make such determinations as are necessary to accomplish the purposes of the Plan with respect to individual Participants or classes of such Participants.

(b) The Employer shall notify the Plan Administrator of facts relevant to such determinations, including without limitation, length of service, compensation for services, date of death, permanent disability, granting or terminating of leave of absence, age, retirement and termination of service for any reason (but indicating such reason), and termination of participation. The Employer shall also notify the Plan Administrator of all other facts which may be necessary for the Plan Administrator to discharge its responsibilities hereunder.

ARTICLE 11

AMENDMENT OR TERMINATION

11.1 Amendment or Termination of Plan.

(a) The Employer reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan or Benefit Program.

(b) Any such amendment or termination shall be effective as of the date specified by the Employer. An amendment may be effected by establishment, modification, or termination of a Benefit Program by Employer. Any such amendment or termination may take effect retroactively or otherwise.

(c) In the event of a termination or reduction of Benefits under the Plan or any Benefit Program, the Plan shall be liable only for benefit payments due and owing as of the effective date of such termination or reduction,

and no payments scheduled to be made on or after such effective date shall result in any liability to the Plan, the Plan Administrator, the Employer, or any agent thereof.

11.2 Form of Amendment or Termination. Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing, duly certified, reflecting that such change has been authorized by Employer or the Plan Administrator.

ARTICLE 12

MISCELLANEOUS

12.1 Exemption for ERISA. This Plan is exempt from the Employers Retirement Income Security Act of 1974 pursuant to 29 U.S.C. 1003(b).

12.2 No Guarantee of Employment, etc. Neither the maintenance of the Plan nor any part thereof shall be construed as giving any Participant hereunder or other Employees any right to remain in the employ of the Employer and none of the terms hereof shall be construed as an express or implied contract between the Employer and any Participant or Beneficiary. All terms and conditions of this Plan are subject to unilateral modification, or termination by Employer. No commissioner, officer, or Employee of the employer in any way guarantees to any Participant or Beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

12.3 Required Information to be Furnished.

(a) Each Participant and Beneficiary will furnish to the Plan Administrator such information as the Plan Administrator considers necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Participant or Beneficiary of such true, full and complete information as the Plan Administrator may request.

(b) Any communication, statement or notice to a Participant and Beneficiary addressed to the last post-office address filed with the Plan Administrator, or if no such address was filed with the Plan Administrator, then to the last post-office address of the Participant or Beneficiary as shown on the Employer's records, will be binding on the Participant or Beneficiary for all purposes of this Plan and neither the Plan Administrator nor the Employer shall be obliged to search for or ascertain the whereabouts of any Participant or Beneficiary.

12.4 Nonalienation. To the fullest extent permitted by law, Participants and Beneficiaries shall have no right to assign, transfer, hypothecate, encumber, commute or anticipate an interest in any Benefits under the Plan, and the payment of Benefits shall in no way be subject to any legal process to levy upon or attach the same for payment of any claim against any Participant or Beneficiary.

12.5 Recovery of Overpayments. Notwithstanding any other provision of the Plan to the contrary, the Plan Administrator shall be authorized on behalf of the Plan to institute or cause to be instituted action to recover an overpayment of Benefits made pursuant to the Plan to any Participant or Beneficiary as authorized by the Code.

12.6 Payment of Benefits to Persons Under Legal Disability. Whenever and as often as any person entitled to payments under the Plan shall be determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the Plan Administrator, in its sole discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to such person's Spouse or to any other person, in any manner the Plan Administrator considers advisable, to be expended for the person's benefit. The decision of the Plan Administrator shall, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof of the Plan, the Employer, and the Plan Administrator.

12.7 Controlling Law. To the extent not preempted by the law of the United States of America, the laws of the State of Utah shall be the controlling state law in all matters relating to the Plan and shall apply.

12.8 Severability. If any provisions of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if said illegal and invalid provisions had never been included herein.

12.9 Limitations and Provisions. The provisions of the Plan and any Benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other Employee benefit Plan maintained by the Employer shall be paid solely in accordance with the terms and provisions of such Plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other Plan.

12.10 Gender and Number. Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

12.11 Headings. All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set for thereunder.

12.12 Counterparts. This Plan may be executed in several counterparts, and each shall be an original without reference to the others.

IN WITNESS WHEREOF, and as evidence by the adoption of this Plan, **GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT** has caused its authorized officers to duly execute this Plan this _____ day of _____, _____.

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

By: _____

Title: _____

Attest:

_____

125 CAFETERIA PLAN **EXHIBIT A**

FOR GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

ARTICLE 1

1.1 Purpose of Plan. The purpose of the Plan is to provide Eligible Employees of the Employer with the opportunity to choose between taxable Compensation and Qualified Benefits made available under or in conjunction with the Plan. Such Qualified Benefits shall be as described in the Benefit Programs outlined herein, which Benefit Programs are incorporated herein and form part of the Plan.

1.2 Effective Date. The effective date of this Plan is May 1, 2019.

1.3 Source of Funds. The Plan and Benefit Programs forming part of the Plan shall be funded and maintained by contributions from Participants made pursuant to salary reduction agreement[s] with the Employer as prescribed under the Plan, and by such other contributions of the Employer, Participants and Beneficiaries to the extent described in a Benefit Program.

1.4 Tax Compliance.

(a) The Plan, and certain or all of the Benefit Programs forming part of the Plan, are intended to result in favorable tax treatment to Participants, Beneficiaries or the Employer, as the case may be. The Plan is therefore intended to comply with any requirements of the Internal Revenue Code (the **"**Code**"**) and regulations there under which impose conditions to such favorable tax treatment. The Plan is specifically intended to qualify as a **"**cafeteria Plan**"** under Section 125 of the Code.

(b) To the extent that any Benefit Program or other feature of the Plan is required to satisfy a standard or other prerequisite to favorable tax treatment, the Plan is intended to facilitate and ensure compliance therewith. Notwithstanding any other terms of the Plan, as with respect to any Benefit Program subject to such prerequisites, the

terms of such Benefits Program, including those relating to coverage and Benefits, are hereby intended to be legally enforceable, and each such Benefit Program is intended to be maintained for the exclusive benefit of Eligible Employees.

(c) Each Benefit Program or other component of the Plan may be deemed to be, and shall be treated as, a separate Plan to the extent required or permitted by law, as determined by the Plan Administrator or other legal authority. In the event a Benefit Program, or any portion thereof, is determined to have failed to comply with one or more prerequisites to favorable tax treatment as prescribed under the Code or applicable regulations, that Benefit Program or portion thereof shall be deemed to be and shall be treated as a separate benefit Plan, and the remaining Benefit programs, or portions thereof, shall not be affected by such non-compliance.

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

ARTICLE 2
DEFINITIONS

When used in the Plan, certain terms are capitalized and shall have the respective meanings set forth in this Article or in certain other Articles of the Plan.

Beneficiary. **"**Beneficiary**"** means a person who is eligible to receive Benefits under a Benefit Program maintained under the Plan by reason of another individual's active or former service with the Employer.

Benefits. **"**Benefits**"** means any amounts paid to a Participant for

Qualified Benefits available from time to time under the Plan.

Benefit Program. **"**Benefit Program**"** means the Health Care Reimbursement Program, Premium Payment Plan, and the Dependent Day Care Assistance Program as set forth in this Plan.

COBRA. **"**COBRA**"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

Code. **"**Code**"** means the Internal Revenue Code of 1986, as amended from time to time.

Compensation. An Eligible Employee's **"**Compensation**"** for any Plan Year means the Compensation paid to the Eligible Employee by the Employer during that period which is currently treated as wages for income tax withholding purposes pursuant to Code Section 3401(a)(determined without regard to any rules under said Code Section that limit the remuneration included in wages based on the nature or location of the employment or the services performed), plus all other payments of Compensation to the Eligible Employee by the Employer for such period which is not included above, but which is subject to reporting under Code Section 6401(d) and 6051(a)(3), and further including amounts contributed by the Eligible Employee under a salary reduction agreement with the Employer which are excludable from taxable income under Code Section 125, 457, 402(g),and 414(h).

Dependent. Except as otherwise provided under the Plan, the term **"**Dependent**"** with respect to a Participant (or, if the Participant is married, by the Participant and Spouse) shall have the meaning of that term given by section 152 of the Code, as amended from time to time. Solely for purposes of the Medical Expense Reimbursement Program, Dependent includes a child (son, daughter, stepson, stepdaughter, or child legally adopted) of a participant, who has not attained age 27 as of the end of the taxable year, regardless of whether that child is married or meets the residency, support, and other tests described in IRC §152(c)for a dependent.

Dependent Day Care Assistance Program. The **"**Dependent Day Care Assistance Program**"** is a Benefit Program, the terms and conditions of which are set forth in Article 6.

Eligible Employee. Eligible Employee means any Employee working for and compensated by Employer who satisfies the eligibility requirements of the Plan as prescribed in Section 3.1 and as defined by the Employer.

Employee. For purposes of this document, Employee means an individual who works for the Employer in an active Employee-Employer relationship; is eligible to participate in any Plan established under this document; and receives wages for employment with the Employer.

Employer. "Employer**"** means GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT, a governmental entity of the State of Utah which has taken all necessary steps to adopt this Cafeteria Plan.

Enrollment. "Enrollment**"** shall be the period beginning sixty (60) days prior to the commencement of each Plan Year and ending thirty (30) days prior to the commencement of each Plan Year. In the case of an Employee who first becomes eligible to participate in a Plan after the commencement of a Plan Year, such Employee shall have sixty (60) days following the date the Employee commences work to complete the Salary Reduction agreement and deliver them to Employer or the Plan Administrator.

Health Care Reimbursement Program. The **"**Health Care Reimbursement Program**"** is a Benefit Program, the terms and conditions of which are set forth in Article 5.

Highly Compensated Employee. "Highly Compensated Employee**"** means, with respect to any Plan year, an Employee of the Employer who meets the definition of highly compensated in Code Section 414(q) and Section 125 (b)(1) and (d), as amended from time to time.

Key Employee. A **"**Key Employee**"** is any current or former Employee of the Employer (and the Beneficiaries of such Employee) who at anytime during the determination period was an Employee that met or meets the definition of a Key Employee in Code Section 416(i)(l), as amended from time to time.

Participant. A **"**Participant**"** is a current Eligible Employee who has elected to participate and has enrolled in the Plan for the Plan Year pursuant to the procedures prescribed in Article 4.

Plan. "Plan**"** means the Cafeteria Plan created by this document,

including all Benefit Programs hereunder, and all documents associated with the Plan or any Benefit Program.

Plan Administrator. The **"**Plan Administrator**"** is the person, committee, entity or other third party designated under Article 9.1 to serve as administrator of the Plan. In the absence of such designation, the Employer shall serve as the Plan Administrator.

Plan Year. "Plan Year**"** means the 12-month participation period beginning on January 1st and ending on December 31st or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year. If the effective date under Section 1.2 is other than January 1st, the initial Plan Year shall be from the effective date until the next December 31st.

Qualified Benefits. "Qualified Benefits**"** shall mean a benefit under the Benefit Program[s] described herein.

Qualified Expense. "Qualified Expense**"** shall mean any amount paid or incurred by a Participant for Qualified Benefits not otherwise reimbursed under any other source.

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

Spending Account[s]. "Spending Account[s]**"** shall mean the account[s] established in the Participant**'**s name and which is used to record amounts allocated to a Participant for a Benefit Program and their expenditure for Qualified Benefits.

Spouse. "Spouse**"** means a person to whom a Participant is legally married. An individual shall be deemed to be a **"**Spouse**"** of a Participant as with respect to any expense which is payable or reimbursable under the Plan if that individual is legally married to the Participant at the time the expense is incurred.

Status Change, Family Status Change, and/or Employment Status Change. "Status Change, Family Status Change and/or Employment

Change**”** means a change in Status, family status or employment status as defined in Article 4.5 of this Plan.

ARTICLE 3
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility Requirements. Each Eligible Employee shall be eligible to become a Participant on the first day of employment. An Eligible Employee shall have sixty (60) days following the date the Employee commences work to complete the Salary Reduction Agreement and to deliver the same to Employer's Plan Administrator. If the Plan Administrator does not receive the Salary Reduction Agreement form within sixty (60) days of employment, the Employee shall not be eligible to participate in the Plan until the next Plan Year.

3.2 Cessation of Participation Generally. A Participant shall cease to be a Participant in the Plan as of the earliest of:

(a) the first day of a Plan Year for which the Participant does not elect to participate in any Benefit Program;

(b) the date a Participant ceases to be an Eligible Employee and thereafter fails to make required or voluntary contributions under the Plan; or

(c) the date on which the Plan is terminated.

3.3 Family Medical Leave. A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (**“**FMLA Leave**”**) may revoke his election to participate under any Benefit Program offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall be in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her FMLA Leave, the Participant may elect to be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA Leave, and with such other rights to revoke or change elections as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on FMLA Leave shall have no greater rights to Benefits for the remainder of the Plan Year in which the FMLA Leave commences as other Plan

Participants.

ARTICLE 4
PARTICIPATION ELECTIONS PROCEDURES

4.1 Election Rights. Each Eligible Employee who has satisfied the eligibility requirements of Section 3.1 may elect to participate in any or all of the Benefit Programs made available under the Plan. An Eligible Employee's participation in any Benefit Program shall be subject to the terms and conditions of the Benefit Programs as set forth in the respective Articles of this Plan.

4.2 Effect of Election. For each Plan Year, an Eligible Employee may elect with respect to any Benefit Program to have the Employer reduce a portion of his or her Compensation, and to have such elected amount made available under the Benefit Program to pay for Qualified Expenses incurred by or on behalf of the Eligible Employee and his or her Beneficiaries. An election so made by an Eligible Employee shall constitute the Eligible Employee's Salary Reduction Agreement with the Employer allowing for a reduction in the Eligible Employee's Compensation in an amount equal to the amount to be made available under the Benefit Program to cover Qualified Benefits for and on behalf of the Eligible Employee.

4.3 Election procedures.

(a) At least 60 days prior to the commencement of each Plan Year, the Plan Administrator shall make available to each Eligible Employee a Salary Reduction Agreement in regard to participation in the Plan for the next Plan Year. In the case of an Employee who first becomes eligible to participate in the Plan after the commencement of a Plan Year, such participation Salary Reduction Agreement shall be made available as prescribed under Section 3.1.

(b) Each Eligible Employee who desires to participate in a Benefit Program for a Plan Year shall so designate such on the Salary Reduction Agreement, and shall further specify the amount of his or her Compensation to be reduced and allocated to each Benefit Program.

(c) To be effective for any Plan Year, a Salary Reduction

Agreement must be completed and returned to the Plan Administrator or its delegate at least thirty (30) days prior to the first day of that Plan Year. If an Eligible Employee fails to deliver a Salary Reduction Agreement to the Plan Administrator prior to the first day of a Plan Year, the Eligible Employee shall not be eligible to participate in any Benefit Program for that Plan Year.

(d) An Eligible Employee must complete and deliver a Salary Reduction Agreement to the Plan Administrator for each Plan Year for each Benefit Program in which the Eligible Employee desires to participate.

4.4 Irrevocable Status of Elections. Except as otherwise provided in this Article 4, any election made or deemed to have been made by an Eligible Employee with regard to participating or declining to participate in any Benefit Program offered within the Plan and with respect to any Plan Year shall be irrevocable for the duration of that Plan Year. During Family Medical Leave, a Participant may exercise whatever rights such Participant has under the Family Medical Leave Act and regulations promulgated thereunder as more fully set forth in Article 3.3.

4.5 Status Changes, Family or Employment Status Changes.

(a) Notwithstanding Section 4.4 above, a Participant may revoke the Salary Reduction Agreement with respect to a Benefit Program in effect for a Plan Year or, alternatively, may modify a prior election to take effect for the remainder of the Plan Year, if the revocation and the new election or modification, as the case may be, is on account of and consistent with a Status Change, Family Status Change or Employment Status Change. In this regard, a benefit election revocation or modification shall be deemed to be consistent with a Status Change, Family Status Change and/or Employment Change only if the revocation or modification is necessary or appropriate as a result of the Status Change, Family Status Change and/or Employment Change.

(b) For purposes of subsection (a) above, a **"**change in family status,**"** **"**Employment Status Change,**"** and/or **"**change in status**"** as with respect to a Participant shall include the following:

(i) the marriage, divorce or legal separation of the

Participant;

(ii) the death of the Participant's Spouse or Dependent;

(iii) the birth or adoption of a child of the Participant;

(iv) the commencement or termination of employment of the Participant's Spouse;

(v) a change from part-time to full-time employment status (or vice versa) by the Participant or the Participant's Spouse;

(vi) the taking of an approved unpaid leave of absence by the Participant or the Participant's Spouse which leave shall include entering into or returning from **"**uniformed service**"** as defined under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA); or the occurrence of a special Enrollment period as defined in Section 9801(f) of the Code);

(vii) a significant change in the heath coverage of the Participant or the Participant's Spouse attributable to the Spouse's employment; or

(viii) such other events that the Plan Administrator determines will permit a change or revocation of an election during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) Any new election made under subsection (a) above shall be effective at such time as the Plan Administrator shall prescribe, but not earlier than the first pay period beginning after the Status Change, Family Status Change and/or Employment Change form is completed and returned to the Plan Administrator or its delegate. Status Change, Family Status Change and/or Employment Changes must be made within 60 days of when the event occurred. If the Status Change, Family Status Change and/or Employment Change form is not received by the Plan Administrator within sixty (60) days of the change in family status, the Status

Change, Family Status Change and/or Employment Change form shall be invalid.

4.6 Effect of Separation From Service.

(a) Except as specifically provided under the Plan, a Participant who separates from service during a Plan Year may revoke all existing benefit elections and terminate the entitlement to the reimbursement of expenses incurred during the Plan Year after the separation of service.

(b) To the extent required or permitted under the Plan, a Participant who separates from service may elect to continue to make contributions to the Plan to provide for the funding of Benefits for the remainder of that Plan Year. If such a Participant fails to timely make any required contributions, the Participant shall not be entitled to reimbursements under the Plan. (Refer to COBRA requirements under Article 8)

(c) However, nothing in this Article 4.6 shall prohibit the payment of Benefits for Qualified Expenses with respect to claims arising prior to the Participants termination of participation. Also, a former Participant who continues to receive Compensation from the Employer and for whom payroll deductions continue to be made shall remain a Participant for all purposes until such Compensation ceases.

(d) A Participant who separates from service may elect to pre-pay the remaining obligation under the current Salary Reduction Agreement. The Participant may then apply for reimbursement throughout the end of that Plan Year.

(e) Moreover, a terminated Participant shall be entitled to reimbursement of claims for Qualified Expenses incurred prior to his or her termination of employment, but only if the Participant (or his or her estate) applies for such reimbursement on or before ninety (90) days following the Participant**'**s termination of participation or ninety (90) days following the close of the Plan Year, whichever is applicable.

(f) A Participant whose benefit election[s] for a Plan Year are revoked under either subsection (a) or (b) above shall not be

entitled to make any new benefit elections in regard to the remaining portion of that Plan Year of separation. A former Participant, who returns to service as an Eligible Employee within 30 days, may have the previous election reinstated for the remainder of that Plan Year. If the former Participant returns to service as an Eligible Employee after 30 days, that Employee may make a new election or resume the previous election for the remainder of that Plan Year.

4.7 Payment of Contributions While on FMLA Leave.

A Participant who takes an unpaid leave of absence under the Family and Medical Leave Act of 1993 (**"**FMLA Leave**"**) and who elects to continue participation under this Plan shall be responsible for making the required contributions under the health care savings account offered under this Plan during the period of the FMLA Leave. The manner in which such payments are made shall be determined by the Employer in its sole discretion, among the following alternatives:

(a) Prepayment: The Participant may prepay the contributions due during the FMLA Leave period. Prepayment may not be required as a condition to remaining in the Plan, and prepayment may not be the sole option of making contributions hereunder.

(b) Pay-As-You-Go: The contributions due during the FMLA Leave period may be paid based on the same schedule as payments would have been due if the Participant had not been on FMLA Leave, on the same schedule as COBRA payments are made, under the Employer's existing rules for payment by Employees on leave without pay, or on any other schedule voluntarily agreed upon by the Plan Administrator and the Participant.

(c) Catch-Up Option: The Employer may advance the contributions on behalf of the Participant, and may recoup such contributions upon the Participant's return to employment. The **"**Catch-Up Option**"** shall be applied in a manner consistent with Prop. Treas. Reg. Sec. 1.125-3.

Prepayments may be made from salary, vacation pay or sick pay, to the extent permitted by applicable law. The Prepayment Option and Catch-Up Option may not be offered without also offering the Pay-As-You-Go Option.

If the Employer chooses more that one payment option the Employee may choose among the options.

4.8 Uniformed Service Under USERRA. A Participant who is absent from employment with the Employer on account of being in "uniformed service," as that term is defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), may elect to continue participation in the Plan. The coverage period shall be in accordance with USERRA 4317 as amended from time to time. The Participant shall be responsible for making the required contributions during the period during which he or she is in "uniformed service." The manner in which such payments are made shall be determined by the Employer, in a manner similar to Article 4.7 (regarding the payment of contributions with respect to FMLA Leave). A 2% administrative fee may be charged in accordance with USERRA. A Participant whose coverage under the Health Care Reimbursement Program is terminated on account of his or her being in "uniformed service," and is later reinstated, shall not be subject to a new exclusion or waiting period requirement imposed by such Plan, provided that such requirements would not have been imposed if coverage had not been terminated as a result of "uniformed service."

4.9 Changes by a Plan Administrator. The Plan Administrator may adopt such rules and take such actions as it deems necessary or desirable to assure that the various statutory or other limitations on Benefits provided to prescribed classes of Participant are satisfied. Such action may include a modification of any election made by a Participant as to the amount of salary reduction contributions to be made by the Participant under the Plan during a Plan Year.

ARTICLE 5
HEALTH CARE REIMBURSEMENT PROGRAM

5.1 Purpose of Program. The purpose of the Health Care Reimbursement Program as described in this Article 5 is to provide Eligible Employees with the opportunity to elect for each Plan Year to have a portion of their taxable Compensation reduced, and to have such elected amount allocated and made available to reimburse them for Qualified Medical Expenses incurred during such Plan Year which are not payable or reimbursable under a Group Medical Plan, or from any other Plan or source.

5.2 Status as Accident or Health Plan. It is the intention of the Employer that the Health Care Reimbursement Program qualify as an "accident or health Plan" within the meaning of Section 105(e) of the Code, and that Benefits provided under the Health Care Reimbursement Program to or on behalf of Eligible Employees, or their Spouses or Dependents, be eligible for exclusion from their gross income pursuant to Sections 105(b),106 and 125 of the Code.

5.3 Enrollment in Program. Each Eligible Employee may elect to enroll in the Health Care Reimbursement Program for a Plan Year pursuant to the procedures set forth in Sections 4.3. and 3.1. Such election shall specify the amount of the Compensation for that Plan Year which the Eligible Employee directs to have reduced and made available for reimbursement of Qualified Medical Expenses during that Plan Year.

5.4 Maximum Annual Benefits. The maximum amount of Compensation which an Eligible Employee may elect to have reduced and set aside on the Eligible Employee's behalf under the Health Care Reimbursement Program for Plan Year, and thus the maximum amount of reimbursements which may be made to the Eligible Employee for Qualified Medical Expenses incurred during the Plan Year is $2,700.

5.5 Spending Accounts. The Plan Administrator shall establish a separate Health Care Spending Account for each Eligible Employee who elects to participate in the Health Care Reimbursement Program for a Plan Year. Such Spending Account shall be credited with the salary reduction contribution which the Eligible Employee has elected to have set aside for the Plan Year under the Health Care Reimbursement Program, and shall be charged with all reimbursements and any administrative expenses made from or assessed against such Spending Account for that Plan Year.

5.6 Conditions to Reimbursement. A Participant shall be entitled to a reimbursement from his or her Health Care Spending Account for a Plan Year only if the following conditions are satisfied:

(a) The expense to which the reimbursement relates is a Qualified Medical Expense as defined in Section 5.7 below;

(b) Such expense was incurred during that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant was enrolled in the Health Care Reimbursement

Program; and

(c) The Participant has complied with the Health Care Reimbursement procedures prescribed under Article 7.

5.7 Qualified Medical Expenses. A **"**Qualified Medical Expense**"** with respect to a Participant means an expense incurred for the medical care, as defined in Section 213 of the Code and as allowed by the Internal Revenue Service rules for Flexible Spending Accounts, of Participant, or for the Spouse or Dependent of the Participant.

For purposes of establishing the status of an expense as a Qualified Medical Expense, the term **"**Dependent**"** as with respect to a Participant is defined in Article 2. In addition, and solely for purposes of this Health Care Reimbursement Program, a child of a divorced Participant shall be treated as a Dependent of the Participant for a Plan Year if more than one-half of the child's support for the year is provided by the Participant. Such status shall exist even if the Participant is not the custodial parent with respect to the child or is otherwise not eligible to claim a personal exemption education with respect to such child for income tax purposes.

5.8 Timing of Expense Incurrence. A Qualified Medical Expense is reimbursable from a Participant's Health Care Spending Account for a Plan Year only if such expense is incurred during that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant is enrolled in the Health Care Reimbursement Program. In this regard, an expense is deemed to have been incurred by a Participant on the date the Participant or Beneficiary is provided with medical care that gives rise to the expense, and not when the Participant or individual is billed, charged for or pays the medical care. Accordingly, an otherwise Qualified Medical Expense is not reimbursable from a Participant's Health Care Spending Account if such expense was incurred prior to the date on which the Participant enrolled in the Health Care Reimbursement Program. Similarly, reimbursements may not be made from a Participant's Health Care Spending Account for any Plan Year as with respect to any expense incurred prior to or after that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year. However, reimbursements of Qualified Medical Expenses incurred during a Plan Year may be made after the end of the Plan Year as set forth in Section 7.2, 7.3 and 7.4.

5.9 Uniform Availability of Benefit. A Participant who elects to participate in the Health Care Reimbursement Program for a Plan Year shall be entitled at all times during that Plan Year to reimbursements from the Health Care Spending Account. The amount of reimbursements to which the Participant is so entitled as of any date is an amount equal to the total annual benefit elected by the Participant pursuant to Section 5.4 (or, if the Participant has modified such elected benefit amount, equal to the modified amount), reduced by any prior reimbursement or expenses charged to such Spending Account for that Plan Year. Such right to reimbursement as of any date shall be without regard to the amount of the Participant's Compensation which has been reduced and allocated to the Participant's Health Care Spending Account as of that date.

5.10 State Medicaid Benefits Rights. Notwithstanding any provision of the Plan to the contrary, the following rules shall apply.

(a) Payment for Benefits with respect to a Participant under the Health Care Reimbursement Program shall be made in accordance with any assignment of rights made by or on behalf of such Participant, or a Beneficiary of the Participant, as required by a State Medicaid Plan.

(b) The fact that an individual is eligible for or is provided medical assistance under a State Medicaid Plan shall not be taken into account in regard to the individual's Enrollment as a Participant or Beneficiary in the Health Care Reimbursement Program, or in determining or making any payments for Benefits of the individual as a Participant or Beneficiary in the Health Care Reimbursement Program.

(c) Payments for Benefits under the Health Care Reimbursement Program shall be made to a State in accordance with any State law which provides that the State has acquired the rights with respect to a Participant for items or services constituting medical assistance under a State Medicaid Plan.

(d) For purposes of this Section 5.10, a **"**State Medicaid Plan**"** means a State Plan for medical assistance approved under Title XIX of the Social Security Act.

5.11 Special Enrollment. A Participant's revocation or

amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

(1) if a judgment, decree, or order (collectively, **"**Order**"**) results from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order defined in Section 609 of ERISA) that requires accident or health coverage for an Employee**'**s Dependent Child, and

(2) the Employee changes his or her election to provide coverage for the Dependent Child if the Order requires coverage under the Employee's plan; or

(3) the Employee changes his or her election to revoke coverage for the Dependent Child if the Order requires the former spouse to provide coverage.

5.12 Medicare / Medicaid Entitlement. A Participant's revocation or amendment of participation during the Plan Year, and new election for the remainder of the Plan Year, is allowable:

(a) if the Employee, Spouse, or Dependent Child becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of the benefits under Section 1928 of the Social Security Act (the program for the distribution of pediatric vaccines); and

(b) the Employee changes his or her election to revoke coverage for that Employee, Spouse or Dependent Child under the Plan.

5.13 Indemnification of Employer and/or Plan Administrator by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for Eligible Medical Care Expenses, such Participant shall indemnify and reimburse the Employer and/or Plan Administrator for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

ARTICLE 6
DEPENDENT DAY CARE ASSISTANCE PROGRAM

6.1 Purpose of Program. The purpose of the Dependent Day Care Assistance Program as described in this Article 6 is to provide Eligible Employees with the opportunity to elect for each Plan Year to have a portion of their taxable Compensation reduced, and to have such elected amount allocated and made available to reimburse them for Qualified Dependent Day Care Expenses incurred during such Plan Year which are not payable or reimbursable from any other Plan or source.

6.2 Status as Dependent Day Care Assistance Program. It is the intention of the Employer that the Dependent Day Care Assistance Program qualify as a **"**Dependent Day Care Assistance Program**"** within the meaning of Section 129(d) of the Code, and that reimbursements provided under the Dependent Day Care Assistance Program to Participants be eligible for exclusion from their gross income pursuant to Section 129(a) of the Code.

6.3 Enrollment in Program. The Plan Administrator shall provide each Eligible Employee with a written notice of the availability of the Dependent Day Care Assistance Program including the terms and conditions of participation. An Eligible Employee may thereupon elect to enroll in the Dependent Day Care Assistance Program for a Plan Year pursuant to the procedures prescribed in Section 4.3. Such election shall specify the amount of the Compensation for that Plan Year which the Eligible Employee directs to have reduced and made available for the reimbursement of Qualified Dependent Day Care Expenses incurred during that Plan Year.

6.4 Maximum Annual Benefits.

(a) Subject to subsection (b) below, the maximum amount of Compensation which a Participant may elect to have reduced and set aside on the Participant**'**s behalf under the Dependent Day Care Assistance Program for a Plan Year, and thus the maximum amount of reimbursements which may be made to the Participant for Qualified Dependent Day Care Expenses incurred during the Plan Year, is $5,000.

(b) Notwithstanding subsection (a) above, the maximum annual benefit which a Participant may elect for a Plan Year shall be limited to the least of the amounts set forth below:

(i) $2,500, in the case of a married Participant if the Participant and the Participant's Spouse will file a separate federal income tax return for the tax year which coincides with such Plan Year;

(ii) the total taxable Compensation and other earned income of the Participant from the Employer, for that Plan Year; and

(iii) in the case of a married Participant, the total taxable Compensation and other earned income of the Participant's Spouse for that Plan Year.

(iv) The amount Participant elects to set forth pursuant to Article 6.3 above.

Notwithstanding the foregoing, the additional limitations prescribed above shall be imposed with respect to an Eligible Employee for a Plan Year only if at the time of the Eligible Employee's election the Plan Administrator knows or has reason to know that the circumstances giving rise to such limitation in fact exist or will exist with respect to the Eligible Employee for that Plan Year.

(c) For purposes of subsections (b)(ii) and (iii) above, a Participant shall be deemed to be married with respect to a Plan Year if the Participant is so married to a Spouse on the last day of that Plan Year.

(d) For purposes of subsection (b)(iii) above, the Spouse of a married Participant shall be deemed to have earned income for any month during a Plan year in which such Spouse is either physically or mentally incapable of self-care, or is a full-time student during at least five (5) calendar months during that Plan Year. The amount of such deemed earned income for each such month is $200 if the Participant has one Qualifying Individual (as defined in Section 6.7 below), and $400 per month if the Participant has more than one Qualifying Individual.

(e) The Plan Administrator may, in its sole discretion, secure from an Eligible Employee such information as may be appropriate to determine whether any of the special limitations prescribed in subsection (b) above may be applicable to the Eligible Employee for a Plan Year.

6.5 Spending Accounts. The Plan Administrator shall establish a separate Dependent Day Care Spending Account for each Eligible Employee who elects to participate in the Dependent Day Care Assistance Program for a Plan Year. Such Spending Account shall be credited with the salary reduction contributions which the Eligible Employee has elected to have set aside for the Plan Year under the Dependent Day Care Assistance Program, and shall be charged with all reimbursements and any administrative expenses made from or assessed against such Spending Account for that Plan Year.

6.6 Conditions to Reimbursement. A Participant shall be entitled to a reimbursement from the Dependent Day Care Spending Account for a Plan Year only if the following conditions are satisfied:

(a) The Participant has one or more Qualifying Individuals, as defined in Section 6.7 below, with respect to such Plan Year;

(b) The expense to which the reimbursement request relates is a Qualified Dependent Day Care Expense as defined in Section 6.8 below;

(c) The expense to which the reimbursement request relates was incurred (as defined in Section 6.9 below) during that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant was enrolled in the Dependent Day Care Assistance Program; and

(d) The Participant has complied with the expense reimbursement procedures prescribed under Article 7.

6.7 Qualifying Individuals. For purposes of this Article 6, a person is a **"**Qualifying Individual**"** with respect to a Participant as of any date if as of such date such person is:

(a) a Dependent of the Participant under the age of 13 with

respect to whom the Participant is entitled to a personal exemption deduction for income tax purposes; or

(b) a Dependent or Spouse of the Participant who is physically or mentally incapable of self-care.

6.8 Qualified Dependent Day Care Expenses.

(a) Except as may otherwise be provided below, a **"**Qualified Dependent Day Care Expense**"** with respect to a Participant means an expense for Dependent care which is incurred to enable the Participant to be gainfully employed during a period for which there are one or more Qualifying Individuals with respect to the Participant.

(b) Notwithstanding the foregoing, the following expenses shall not be deemed **"**Qualified Dependent Day Care Expenses,**"** and thus shall not be reimbursable under the Dependent Day Care Assistance Program, these expenses include, but are not limited to:

(i) Any expense associated with providing Dependent care to a Participant's Dependent or Spouse who is a Qualifying Individual by reason of being incapable of self-care, if the Plan Administrator knows or has reason to know such person does not regularly spend at least eight (8) hours each day in the Participant**'**s home.

(ii) Any expense for services provided by a day care center if the Plan Administrator knows or has reason to know that such center either does not comply with all applicable state and local laws and regulations, or does not provide care to more than six (6) individuals on a regular basis during the Plan Year.

(iii) Any expense which the Plan Administrator knows or has reason to know represents the cost of sending a child to an overnight camp.

(iv) Any expense which the Plan Administrator knows or has reason to know represents an amount paid to any individual who is:

(A) a Dependent of the Participant with respect to when the Participant can claim a personal exemption deduction for income tax purposes;

(B) the Spouse of the Participant; or

(C) a child of the Participant who is under the age of 19 as of the last day of the Plan Year.

(v) Any expense which the Plan Administrator knows or has reason to know has been paid or is reimbursable under any other program or from any source (other than this Plan).

(vi) Any expense that is excluded by federal regulations including but not limited to food, clothing, or educational services unless these services are minimal or insignificant and inseparable from the portion of the expense that is for care, or for the individual's well being and protection.

(c) For purposes of establishing the status of an expense as a Qualified Dependent Day Care Expense, the term **"**Dependent**"** with respect to a Participant is as defined in Article 2; except that a child of a divorced Participant shall be treated as a Dependent of the Participant for a Plan Year only if the Participant has custody of the child for a longer period during the Plan Year than the other parent. Such status shall exist even if the Participant is not otherwise eligible to claim a dependency exemption deduction with respect to such child for income tax purposes by reason of a written release to such exemption claim made under Code Section 152(e).

6.9 Timing of Expense Incurrence. A Qualified Dependent Day Care Expense is reimbursable from a Participant's Dependent Day Care Spending Account for a Plan Year only if such expense is incurred during the Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year and while the Participant is enrolled in the Dependent Day Care Assistance Program. In this regard, an expense is deemed to have been incurred by an individual on the date on which the Qualifying Individual to whom the expense relates is provided with the Dependent care that gives rise to the

expense, and not when the Participant or Qualifying Individual is billed, charged for or pays for the Dependent care. Accordingly, an otherwise Qualified Dependent Day Care Expense is not reimbursable from a Participant's Dependent Day Care Spending Account if such expense was incurred prior to the date on which the Participant enrolled in the Dependent Day Care Assistance Program. Similarly, reimbursements may not be made from a Participant's Dependent Day Care Spending Account as with respect to any expense incurred prior to or after that Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year. However, reimbursements of Qualified Dependent Day Care Expenses incurred during a Plan Year may be made after the end of the Plan Year as prescribed in Article 7.

6.10 Limited Availability of Benefits. The amount to which a Participant is entitled as a reimbursement under the Dependent Day Care Spending Account as of any date during a Plan Year is limited to the total amount of the Participant's elective contributions made to such account for the Plan Year as of such date, reduced by any prior reimbursements and administrative expenses charged to that account for that Plan Year.

6.11 Plan Administrator Rules. The Plan Administrator may adopt such rules as it deems necessary or desirable to impose limitations on the amount of contributions elected to be made by Participants under the Dependent Day Care Assistance Program for the purpose of assuring that the limitations prescribed under this Article 6 are satisfied.

6.12 Annual Benefit Statement. The Plan Administrator or Employer shall provide to each Participant receiving reimbursements from the Dependent Day Care Assistance Program during a calendar year a written statement setting forth the amounts reimbursed or to be reimbursed to the Participant for such year. Such written statement shall be provided on or before January 31 following the end of the calendar year at issue. In lieu of a separate written statement, the information may be included in the Participant's Form W-2, Wage and Tax Statement, for such year. If as the time such annual benefit statement is being prepared, the Plan Administrator is unable to ascertain the total amount of reimbursement which will be made to a Participant for the year, the Plan Administrator may report in the annual benefit statement a reasonable estimate of the total amount of reimbursements. In this regard, the amount of Compensation which the Participant elected to have set aside under the Dependent Day Care Assistance Program for the year shall be deemed to be a reasonable

estimate of the total amount to be reimbursed to the Participant for the year.

6.13 Indemnification of Employer / Plan Administrator by Participants. If any Participant receives one or more payments or reimbursements under this Plan that are not for Eligible Dependent Day Care Expenses, such Participant shall indemnify and reimburse the Employer and/or Plan Administrator for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements.

ARTICLE 7
EXPENSE REIMBURSEMENT PROCEDURES

7.1 General Rules. Reimbursements of Qualified Expenses under the Plan shall be made to a Participant upon the filing of a prior request for such reimbursement with the Plan Administrator or its delegate. The use of a benefit card shall constitute such a request. The reimbursement for use of a benefit card shall be satisfied by the honoring of the charge on the card with a corresponding reduction of the participants account balance. Any such request, other than use of a benefit card, shall not be acted upon unless it is (i) made on such form as the Plan Administrator may approve for such purpose, (ii) signed by the requesting Participant; and (iii) timely filed with the Plan Administrator or its delegate. All requests for reimbursements under the Plan shall be subject to, and shall be processed in accordance with, the procedures set forth in this Article 7 and such other procedures prescribed from time to time by the Plan Administrator. All such procedures shall be uniformly applied to similarly situated Participants.

7.2 Timing of Requests. Requests for reimbursements under the Plan for Qualified Expenses incurred during a Plan Year may be made at any time during the plan year. In all events, requests for reimbursement under the Plan must be submitted within ninety days (90) days following the end of the Plan Year. Any request for a reimbursement with respect to a Plan Year which is received after the foregoing deadline is ineligible for reimbursement.

7.3 Forfeitures. If the total Qualified Expenses paid or reimbursed to a Participant with respect to any Plan Year are less than the amount set aside for reimbursement by Participant in any Plan Year, the

unused portion shall be forfeited ninety (90) days following an Employee's date of termination from plan participation or ninety (90) days after the end of the Plan Year, whichever is earlier. No Participant shall be entitled to carry over any unused dollar amounts to the next Plan Year or to reallocate the unused portion to any other benefit program, nor shall any Participant be entitled to receive any unused portion in the form of cash.

7.4 Reimbursements. Except as provided in any Plan, contract or arrangement established to provide Benefits, reimbursement of Qualified Expenses shall be made at such time and in such amounts as shall be determined by Employer or the Plan Administrator in accordance with law. The amounts set aside under a Participant's Salary Reduction Agreement for any Plan Year shall be used only to reimburse the Participant for Qualified Expenses incurred for such Plan Year or during the two and one half months ending on the 15th day of the third calendar month immediately following the Plan Year, and only if the Participant applies for reimbursement on or before the dates set forth in Article 7.2 and 7.3 above.

7.5 Minimum Reimbursements. At the discretion of the Plan Administrator, a request by a Participant for a reimbursement under either the Health Care Reimbursement Program or the Dependent Day Care Assistance Program shall be accepted and acted upon if the amount of the request is for at least $25.00 (or, if less, the remaining balance of the Participant's account). The foregoing restriction shall not apply, however, to the final reimbursement to be made to a Participant for a Plan Year.

7.6 Claims Substantiation. No expense reimbursement shall be made to a Participant under the Health Care Reimbursement Program or the Dependent Day Care Assistance Program unless the expense is documented directly by the Administrator or the Participant:

(a) provides an invoice or other written statement from the service provider or other applicable independent third party which evidences that the expense has been incurred and the amount of such expense; and

(b) attests in writing that the expense at issue has not been reimbursed and is not reimbursable under any other Plan.

7.7 Processing Fee. The Plan Administrator may impose upon a Participant a reasonable fee for the processing of a reimbursement under

the Plan. Any such fee shall be charged to the Spending Account of the Participant from which such reimbursement is made. Any such fee shall be in accordance with the agreement between the Plan Administrator and the Employer.

7.8 Nondiscrimination. Notwithstanding any provision of the Plan to the contrary, in no event shall the aggregate amount of reimbursements or other Benefits provided to Key Employees under the Plan for a Plan Year exceed twenty-five percent (25%) of the aggregate amount of such reimbursements or other Benefits provided to all Participants for such Plan Year. The Plan Administrator may adopt such rules as it deems necessary or desirable to assure that the foregoing limitation is satisfied, including imposing restrictions on the amount of contributions which a Key Employee may elect to have set aside under the Plan for a Plan Year. Any such rules shall be uniformly applied to similarly situated individuals.

7.9 Appeals Procedure.

(a) Any Participant or other person who believes that a benefit is then due to such person under the Plan, including one greater than that initially determined by the Plan Administrator, may file an appeal in writing with the Plan Administrator.

(b) The Plan Administrator shall within ninety (90) days of the receipt of an appeal either allow or deny the appeal in writing. A denial of a claim shall be written in a manner calculated to be understood by the claimant and shall include:

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

(ii) specific references to pertinent Plan provisions on which the denial is based;

(iii) a description of any additional material or information necessary for the claimant to perfect the claim for the benefit believed due and an explanation of why such material or information is necessary; and

(iv) an explanation of the Plan's claim review procedure.

(c) A claimant whose claim is denied (or the claimant's duly authorized representative) may, within sixty (60) days after receipt of denial of the claim:

(i) submit a written request for review to the Plan Administrator;

(ii) review pertinent documents; and

(iii) submit issues and comments in writing.

(d) The Plan Administrator shall notify the claimant of its decision on review within sixty (60) days of receipt of a request for review. The decision on review 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 provision on which the decision is based.

(e) The 90-day and 60-day periods described in subsections (b) and (d), respectively, may be extended at the discretion of the Plan Administrator for a second ninety (90) or sixty (60) day period, as the case may be, provided that written notice of the extension is furnished to the claimant prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected.

(f) A claimant may state the reason or reasons forming the basis of the appeal to a benefit under the Plan, and may submit written evidence in support of the appeal made under and in accordance with the procedures set forth in this Section. Such action is not required. However, the failure to state a reason or to submit written evidence in support of an appeal shall permanently bar the claimant from raising such reason or submitting such evidence in any forum at a later date.

(g) Participants and Beneficiaries shall not be entitled to challenge the Plan Administrator's determinations in judicial or administrative proceedings without first complying with the procedures in this Article. The decisions made pursuant to this Section are intended to be final and binding on Participants, Beneficiaries and others.

(h) Notwithstanding the other sections of this Article 7, if the Public Employees Heath Program (PEHP) is the Plan Administrator , the procedure for appealing denied claims shall be administered in accordance with Utah Code Ann. ə 49-11-613 as amended.

ARTICLE 8
COBRA CONTINUATION RIGHTS

8.1 In General. Any Participant and/or Dependent who experiences a Qualifying Event with respect to the Health Care Reimbursement Program shall thereafter be eligible for Benefits under the Health Care Reimbursement Program in such amounts and for such periods as may be mandated under the health care continuation provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and this Article 8.

8.2 Continuation of Coverage. To the extent required by Section 8.1 above, a Qualified Beneficiary who would lose coverage under this Plan as a result of a qualifying event is entitled to elect continuation coverage within the election period under this Plan. Coverage provided under this provision is on a contributory basis. No evidence of good health will be required.

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

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

8.4 Coverage Period. The coverage under this provision will extend for at least the period beginning on the date of a qualifying event

and ending not earlier than the earliest of the following:

(a) the date continuation period under the IRS regulations has been exhausted;

(b) the date on which Employer ceases to provide any flexible spending Plan to any Employee;

(c) the date on which the Qualified Beneficiary fails to make timely payment of the required contribution pursuant to this provision;

(d) the date on which the Qualified Beneficiary first becomes, after the date of the election, covered under any other group health Plan as an Employee or Dependent, or otherwise becomes entitled to Benefits under Title XVIII of the Social Security Act (Medicare).

8.5 Contribution.

(a) A Qualified Beneficiary shall only be entitled to continuation coverage provided such Qualified Beneficiary pays the applicable contribution required under the Plan in full and in advance, except as provided in (b) below. Such contribution shall not exceed the requirements of applicable federal law. A Qualified Beneficiary may elect to pay such contribution in monthly installments.

(b) Except as provided in (c) below, the payment of any contribution shall be considered to be timely if made within thirty (30) days after the date due, or within such longer period of time as applies to or under this Plan.

(c) Notwithstanding (a) and (b) above, if an election is made after a qualifying event during the election period, this Plan will permit payment of the required contribution for continuation coverage during the period preceding the election to be made within 45 days of the date of the election.

(d) A 2% administrative fee may be charged in accordance with COBRA.

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

8.7 Notification to Qualified Beneficiary.

(1) Upon receipt of written notice of a Qualifying Event the Plan Administrator shall then provide written notice to each Qualified Beneficiary of his or her right to continuation coverage under this provision as required by federal law.

(2) The Plan Administrator shall notify any Qualified Beneficiary of the right to elect continuation coverage under this provision as required by federal law. If the qualifying event is the divorce or legal separation of the Participant from the Participant's Spouse or a Dependent child ceasing to be a Dependent child under the terms of this Plan, the administrator shall only be required to notify a Qualified Beneficiary of his or her right to elect continuation coverage if the Qualified Beneficiary notifies the Administrator of such qualifying event occurring after the date of the enactment of the Tax Reform Act of 1986 within sixty (60) days after the date of such qualifying event.

(3) Notification of the requirements of this provision to the Spouse of a Participant shall be treated as notification to all other qualified Beneficiaries residing with such Spouse at the time notification is made.

8.8 Definitions. The terms used in the text of this Article 8 are defined as follows:

(1) **"**Dependents**"** for the purposes of the Health Care Reimbursement Plan, include individuals who are Dependents within the meaning of section 152(a) of the Code. No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee**'**s Spouse are employed by Employer, Dependent children may be covered by either Spouse, but not by both.

(2) **"**Election Period**"** means the 60-day period during which a Qualified Beneficiary who would lose coverage as a result of a qualifying event may elect continuation coverage. This 60-day period begins not later than the date of termination of coverage as a result of a qualifying event and ends not earlier than sixty (60) days after the later of such date of termination of coverage or the receipt of notice of the right to elect continuation coverage under this Plan.

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

(4) **"**Medicare**"** means the Health Insurance for the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

(5) **"**Qualified Beneficiary**"** means an individual who, on the day before the qualifying event for a Participant, is a Beneficiary under this Plan as the Spouse or Dependent child of the Participant. In the case of the termination of a Participant or the reduction in hours of the Participant**'**s employment, the term Qualified Beneficiary includes the Participant. Effective January 1, 1997, a child who is born to (or placed for adoption with) a Qualified Beneficiary who is a Participant during the Coverage Period shall also be a Qualified Beneficiary.

Exception - the term Qualified Beneficiary does not include an individual whose status as a Participant is attributable to a period in which such individual is a nonresident alien who received no earned income from the Employer which constituted income from sources within the United States (within the meaning of Code Section 911(d)(2) and section 861(a)(3)). If an individual is not a Qualified Beneficiary pursuant to this paragraph, a Spouse or Dependent child of such individual shall not be considered a Qualified Beneficiary by virtue of the relationship to such individual.

(f) **"**Qualifying Event**"** means with respect to a Participant, any of the following events which, but for the continuation coverage under this provision, would result in the loss of coverage of a

Qualified Beneficiary:

(1) the death of the Participant;

(2) the termination (except by reason of such Participant's gross misconduct) or reduction in hours of the Participant's employment;

(3) the divorce or legal separation of the Participant from such Participant's Spouse;

(4) the Participant becoming entitled to Benefits under Title XVIII of the Social Security Act (Medicare);

(5) a Dependent child who ceases to be a Dependent child under the terms of this Plan.

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

ARTICLE 9
ADMINISTRATION OF THE PLAN

9.1 Plan Administrator. The Employer may appoint a person, a committee consisting of more than one person, an entity, or other third party to serve as the Plan Administrator and named fiduciary of the Plan. In the absence of such an appointment, the Employer shall serve as such Plan Administrator.

9.2 Powers and Duties of Plan Administrator. Except as specifically provided otherwise, the Plan Administrator shall have final and binding discretionary authority to control and manage the operation and administration of the Plan, including all rights and powers necessary or convenient to the carrying out all of its functions hereunder, whether or not such rights and powers are specifically enumerated herein. In exercising its responsibilities hereunder, the Plan Administrator may manage and administer the Plan through the use of agents (who may include Employees of the Employer). Without limiting the generality of the foregoing, and in addition to the other powers set forth in this Article 9, the Plan Administrator shall have the following express authorities:

(a) To construe and interpret the Plan, decide all questions of eligibility and determine the amount, manner and time of payment of any Benefits hereunder, all in the sole discretion of the Plan Administrator. Any such construction, interpretation, etc., shall be final and binding on Participants, Beneficiaries and all other persons.

(b) To prescribe procedures to be followed by Participants in filing requests for reimbursements of proper expenses, and to authorize payment of such expense reimbursements.

(c) To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, information explaining the Plan.

(d) To receive from the Employer, and from Participants and Beneficiaries, such information, and to maintain records concerning such information, as shall be necessary for the proper administration of the Plan.

(e) To furnish the Employer upon request such annual and other reports with respect to the administration of the Plan as are reasonable and appropriate.

(f) To review and decide claims for Benefits, and the review of the denial of any such claims, pursuant to and to the extent provided in Article 7, including any interpretations of the Plan, which decisions and interpretations the Plan Administrator shall have full discretion and authority to make hereunder.

9.3 Consultation With Advisors. Except as specifically provided herein, the Plan Administrator (or any other fiduciary designated pursuant to Section 9.5) may employ one or more persons to render advice with regard to any responsibility it may have under the Plan. The Plan Administrator may consult with counsel, actuaries, accountants, physicians or other advisors (who may be counsel, actuaries, accountants, physicians or other advisors for the Employer) and may also from time to time utilize the services of Employees and agents of the Employer in the discharge of its responsibilities.

9.4 Records and Reports. The Plan Administrator and Employer shall take all such action as it deems necessary or appropriate to comply

with governmental laws and regulations relating to the maintenance of records, notifications to Participants, filings with the Internal Revenue Service and U.S. Department of Labor, and all other such requirements applicable to the Plan. The Plan Administrator shall be responsible for preparing the Form 5500. The Employer shall be responsible for filing the Form 5500 with the Internal Revenue Service.

9.5 Designation of Other Fiduciaries. The Employer may designate in writing other persons to carry out a specified part or parts of the Plan Administrator's responsibilities hereunder (including the power to designate other persons to carry out a part of such designated responsibility); provided, however, that such designation may not include any power to manage or control assets of the Plan, or to amend the Plan. Any such designation must be accepted by the designated person, who shall acknowledge in writing that such person is a fiduciary with respect to the Plan.

9.6 Obligations of Plan Administrator and Employers.

(a) The Plan Administrator shall make such determinations as are necessary to accomplish the purposes of the Plan with respect to individual Participants or classes of such Participants.

(b) The Employer shall notify the Plan Administrator of facts relevant to such determinations, including without limitation, length of service, Compensation for services, date of death, permanent disability, granting or terminating of leave of absence, age, retirement and termination of service for any reason (but indicating such reason), and termination of participation. The Employer shall also notify the Plan Administrator of all other facts which may be necessary for the Plan Administrator to discharge its responsibilities hereunder.

ARTICLE 10
AMENDMENT OR TERMINATION

10.1 Amendment or Termination of Plan.

(a) The Employer reserves the right at any time and from time to time to amend or terminate in whole or in part any of the provisions of the Plan or Benefit Program.

(b) Any such amendment or termination shall be effective as of the date specified by the Employer. An amendment may be effected by establishment, modification, or termination of a Benefit Program by Employer. Any such amendment or termination may take effect retroactively or otherwise.

(c) In the event of a termination or reduction of Benefits under the Plan or any Benefit Program, the Plan shall be liable only for benefit payments due and owing as of the effective date of such termination or reduction, and no payments scheduled to be made on or after such effective date shall result in any liability to the Plan, the Plan Administrator, the Employer, or any agent thereof.

10.2 Form of Amendment or Termination. Any amendment or termination of the Plan or any part of the Plan shall be made by an instrument in writing, duly certified, reflecting that such change has been authorized by Employer or the Plan Administrator.

ARTICLE 11
MISCELLANEOUS

11.1 Exemption for ERISA. This Plan is exempt from the Employers Retirement Income Security Act of 1974 pursuant to 29 U.S.C. 1003(b).

11.2 No Guarantee of Employment, etc. Neither the maintenance of the Plan nor any part thereof shall be construed as giving any Participant hereunder or other Employees any right to remain in the employ of the Employer and none of the terms hereof shall be construed as an express or implied contract between the Employer and any Participant or Beneficiary. All terms and conditions of this Plan are subject to unilateral modification, or termination by Employer. No commissioner, officer, or Employee of the Employer in any way guarantees to any Participant or Beneficiary the payment of any benefit or amount which may become due in accordance with the terms of the Plan.

11.3 Required Information to Be Furnished.

(a) Each Participant and Beneficiary will furnish to the Plan Administrator such information as the Plan Administrator considers necessary or desirable for purposes of administering the Plan, and the provisions of the Plan respecting any payments hereunder are conditional upon the prompt submission by the Participant or Beneficiary of such true, full and complete information as the Plan Administrator may request.

(b) Any communication, statement or notice to a Participant and Beneficiary addressed to the last post-office address filed with the Plan Administrator, or if no such address was filed with the Plan Administrator, then to the last post-office address of the Participant or Beneficiary as shown on the Employer's records, will be binding on the Participant or Beneficiary for all purposes of this Plan and neither the Plan Administrator nor the Employer shall be obliged to search for or ascertain the whereabouts of any Participant or Beneficiary.

11.4 Nonalienation. To the fullest extent permitted by law, Participants and Beneficiaries shall have no right to assign, transfer, hypothecate, encumber, commute or anticipate an interest in any Benefits under the Plan, and the payment of Benefits shall in no way be subject to any legal process to levy upon or attach the same for payment of any claim against any Participant or Beneficiary.

11.5 Recovery of Overpayments. Notwithstanding any other provision of the Plan to the contrary, the Plan Administrator shall be authorized on behalf of the Plan to institute or cause to be instituted action to recover an overpayment of Benefits made pursuant to the Plan to any Participant or Beneficiary as authorized by the Code.

11.6 Payment of Benefits to Persons Under Legal Disability. Whenever and as often as any person entitled to payments under the Plan shall be determined to be a minor or under other legal disability or otherwise incapacitated in any way so as to be unable to manage such person's financial affairs, or otherwise incapable of giving a valid receipt and discharge for any payment, the Plan Administrator, in its sole discretion, may direct that all or any portion of such payments be made (i) to such person, (ii) to such person's legal guardian or conservator, or (iii) to

such person's Spouse or to any other person, in any manner the Plan Administrator considers advisable, to be expended for the person's benefit. The decision of the Plan Administrator shall, in each case, be final and binding upon all persons. Any payment made pursuant to the power herein conferred shall operate as a complete discharge of the obligations under the Plan in respect thereof of the Plan, the Employer, and the Plan Administrator.

11.7 Controlling Law. To the extent not preempted by the law of the United States of America, the laws of the State of Utah shall be the controlling state law in all matters relating to the Plan and shall apply.

11.8 Severability. If any provisions of the Plan shall be held illegal or invalid for any reason, said illegality or invalidity shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if said illegal and invalid provisions had never been included herein.

11.9 Limitations on Provisions. The provisions of the Plan and any Benefits provided by the Plan shall be limited as described herein. Any benefit payable under any other Employee benefit Plan maintained by the Employer shall be paid solely in accordance with the terms and provisions of such Plan, and nothing in this Plan shall operate or be construed in any way to modify, amend, or affect the terms and provisions of such other Plan.

11.10 Gender and Number. Masculine gender shall include the feminine and neuter, the singular shall include the plural, and the plural shall include the singular, unless the context clearly indicates otherwise.

11.11 Headings. All article and section headings in the Plan are intended merely for convenience and shall in no way be deemed to modify or supplement the actual terms and provisions set for thereunder.

11.12 Counterparts. This Plan may be executed in several counterparts, and each shall be an original without reference to the others.

IN WITNESS WHEREOF, and as evidence by the adoption of this Plan, **GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT** has caused its authorized officers to duly execute this Plan this _____ day of _____, _____.

GREATER SALT LAKE MUNICIPAL SERVICES DISTRICT

By: _____

Title: _____

Attest:

_____