# Park City School District

Cafeteria Plan

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## Table of Contents

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As Adopted Effective September 1, 2004

## ARTICLE I
## INTRODUCTION

**1.1 Establishment of Plan**

Park City School District (the "Employer") hereby amends and restates the Park City School District Cafeteria Plan (the "Plan") established, pursuant to the provisions of Section 125 of the Internal Revenue Service Code of 1986, with an original effective date of September 1, 2003. This amendment and restatement shall be effective September 1, 2004. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to permit an Eligible Employee to pay on a pre-tax Salary Reduction basis for his or her share of premiums under the Group Health Insurance Plans, and to contribute to an account for pre-tax reimbursement of certain Medical Care Expenses and Dependent Care Expenses.

**1.2 Legal Status**

This Plan is intended to qualify as a "cafeteria plan" under Code §125 and regulations issued thereunder and shall be interpreted to accomplish that objective.
The Health FSA Component is intended to qualify as a "self-insured medical reimbursement plan" under Code §105(h), and the Medical Care Expenses reimbursed under that component are intended to be eligible for exclusion from participating Employees' gross income under Code §105(b). The Dependent Care FSA Component is intended to qualify as a "dependent care assistance plan" under Code §129, and the Dependent Care Expenses reimbursed under that component are intended to be eligible for exclusion from participating Employees' gross income under Code §129(a).
Although reprinted within this document, the Health FSA Component and the Dependent Care FSA Component are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code §105 and Code §129. The Health FSA Component is also a separate plan for purposes of applicable provisions of ERISA and COBRA.

## ARTICLE II
## DEFINITIONS

**2.1 Definitions**

"Account(s)" means the Health FSA Accounts and the Dependent Care FSA Accounts described in Sections 7.5 and 8.5, respectively.

"Administrator" means the Business Administrator of Park City School District or such other person or committee as may be appointed from time to time by the Employer to supervise administration of the Plan.

"Benefits" means the Premium Payment Benefits, the Health FSA Benefits and the Dependent Care FSA Benefits.

"Benefit Package Option" means a qualified benefit under Code §125(f) that is offered under a cafeteria plan which, with the application of Code §125(a), is not includible in the gross income of the Participant for purposes of Federal income tax purposes.

"Change in Status" has the meaning described in Section 9.3.

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

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

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan, (b) any salary reduction election under any other cafeteria plan, and (c) any compensation reduction under any Code §132(f)(4) plan. (Wages or salary are determined after salary deferral elections under any 401(k), 403(b) or 408(k) arrangement.)

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code §152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component) and for purposes of the Health FSA Component, any child to whom Code §152(e) applies (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the year) is treated as a dependent of both parents; and (b) for purposes of the Dependent Care FSA Component, a dependent means a qualifying individual as defined in Code §21(b)(1) with respect to the Participant, and in the case of divorced parents, the child shall, as provided in Code §2l(e)(5), be treated as a qualifying individual of the custodial parent (within the meaning of Code §152(e)(1)), and shall not be treated as a qualifying individual with respect to the non-custodial parent. Notwithstanding the foregoing, the Health FSA Component will provide benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Dependent Care Expenses" has the meaning described in Section 7.3.

"Dependent Care FSA Account" means the account described in Section 7.5.

"Dependent Care FSA Benefits" has the meaning described in Section 7.1.

"Dependent Care FSA Component" means the component of this Plan described in Article VII.

"Earned Income" shall have the meaning given to such terms in §129(e)(2) of the Code, but shall not include (a) any amounts received pursuant to any Dependent Care FSA under Code §129; or (b) any other amounts excluded from earned income under Code §32(c)(2), such as amounts received under a pension or annuity, or pursuant to workers' compensation.

"Effective Date" of this Plan means September 1, 2003. Amendment and Restatement Date of this Plan means September 1, 2004.

"Election Form/Salary Reduction Agreement" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Premium Payment Benefits, Health FSA Benefits and Dependent Care FSA Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

"Eligible Employee" means an Employee eligible to participate in this Plan as provided in Section 3.1.

"Employee" means any person who renders service to an Employer in the status of an Employee as the term is defined in Code Section 3121(d). Notwithstanding the preceding sentence, the term Employee shall not include: (a) any individual deemed to be an Employee of an Employer by virtue of Code Section 414(n) of the Code relating to leased employees, or (b) any employee covered under a collective bargaining agreement. The term "Employee" also includes "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

"Employee Contribution" means the premium or cost of a Participant's elective coverage otherwise payable by such Participant for coverage under any Group Insurance Plan.

"Employer" means Park City School District, and any Related Employer that adopts this Plan with the approval of Park City School District. However, for purposes of Article XI and Section 12.3, "Employer" means only Park City School District.

"Employment Commencement Date" means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Group Insurance Benefits" means an Employee's Group Insurance Plan coverage for purposes of this Plan.

"Group Insurance Plan" means the plan(s) identified on Exhibit A attached hereto that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)), providing major medical, dental, or vision benefits through a group insurance policy or policies (including Health Maintenance Organizations). The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Health FSA" means health flexible spending arrangement.

"Health FSA Account" means the account described in Section 7.5.

"Health FSA Benefits" has the meaning described in Section 7.1.

"Health FSA Component" means the component of this Plan described in Article VII.

"Group Insurance Plan" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such Plan), providing major medical type benefits through a group insurance policy or policies (including HMOs). The Employer may substitute, add, subtract or revise at any time the menu of such plans and/or the benefits, terms and conditions of any such plans. Any such substitution, addition, subtraction or revision will he communicated to Participants and will automatically be incorporated by reference under this Plan.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Open Enrollment Period" with respect to a Plan Year means the first 15 days of the month immediately preceding such Plan Year, or other period prescribed by the Administrator.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate during a Plan Year, it shall mean the portion of the Plan Year following the date participation commences as described in Section 3.1; and (b) for Employees who terminate participation during a Plan Year, it shall mean the portion of the Plan Year prior to the date participation ends and any portion of the Plan Year following such termination during which their participation continues terminates as described in Section 3.2.

"Plan" means the Park City School District Cafeteria Plan as set forth herein and as amended from time to time.

"Plan Year" means the 12-month period commencing January 1st and ending on December 31st, except in the case of a short plan year where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year. The Short Plan Year will be from September 1, 2004 to December 31, 2004.

"Premium Payment Benefits" means the Premium Payment Benefits described in Section 6.1.

"Premium Payment Component" means the component of this Plan described in Article VI.

"QMCSO" means Qualified Medical Child Support Order, as defined in ERISA §609(a).

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Related Employer" means any employer affiliated with Park City School District that, under Code §414(b), (c), or (m), is treated as a single employer with Park City School District for purposes of Code §125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay on a pre-tax basis for one or more of the Premium Payment Benefits, Health FSA Benefits or Dependent Care FSA Benefits, as permitted for the applicable Component.

"Spouse" means an individual who is legally married to a Participant as determined under applicable State law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the Dependent Care FSA Component, the term "Spouse" shall not include (a) an individual legally separated from the Participant under a divorce or separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a separate principal residence from the Participant during the last six months of the taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means an individual who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its educational activities are regularly carried on.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

# ARTICLE III
# ELIGIBILITY AND PARTICIPATION

**3.1 Eligibility to Participate**

An individual is eligible to participate in this Plan if the individual: (a) is an Employee, and (b) is regularly scheduled to work at least 20 hours or more per week. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the month if hired between the 1st and 5th of the month, or the Employee may elect coverage effective the first of the next calendar month if hired on or after the 6th of the month, or for any subsequent Plan Year, in accordance with the procedures described in Article IV. A former Employee may continue eligibility for the remainder of the Plan Year in which the Employee ceased to be employed by the Employer. An Employee shall become eligible to participate in the Health Care FSA Component and the Dependent Care FSA Component on the date on which he or she becomes eligible to participate in this Plan. Eligibility for Premium Payment Benefits, however, shall be subject to the additional requirements, if any, specified in the Group Insurance Plans. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the Group Insurance Plans.

**3.2 Participation**

An Employee who is eligible to participate in this Plan shall become a Participant on the later of (a) his or her Employment Commencement Date or (b) the date he or she becomes eligible to participate in the Plan. An eligible Employee who has not completed an application to participate will nonetheless be considered a Participant for purposes of allowing such person to make an initial election mid-year, upon the occurrence of an event that would justify a mid-year election change, as described under Article IX. An Employee who becomes eligible to participate in the Plan and who on such date is a participant in any of the Group Insurance Plans shall automatically become a Participant in the Premium Payment Component of the Plan in accordance with Article VI.

**3.3 Termination of Participation**

A Participant will cease to be a Participant in this Plan upon the earlier of:

(a) the expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Open Enrollment Period for the next Plan Year the Employee elects to continue participating);
(b) the termination of this Plan;
(c) the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction in hours, or any other reason) to be an Eligible Employee;
(d) the date on which COBRA coverage terminates, if such coverage was elected with respect to Health FSA Benefits as described under Section 7.8; or
(e) the date the Participant revokes his or her election to participate under a circumstance when such change is permitted under Article IX.

Reimbursements from the Health FSA and Dependent Care FSA Accounts after termination of participation will be made pursuant to Sections 7.8 and 8.8. Participation in the Premium Payment Component will cease as of the date specified in the applicable Benefit Package Option.

**3.4 Participation Following Termination of Employment**

A former Participant who is rehired within 30 days or less of the date of a termination of employment will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under a Group Insurance Plan is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

**3.5 FMLA Leaves of Absence**

(a) *Health Benefits.* Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee.

A Participant may elect to continue his or her coverage under the Premium Payment and/or Health FSA Component during the FMLA leave. If the Participant elects to continue coverage while on leave and if participant is allowed to return to work, then the Participant will be allowed to re-enter the plan and may pay his or her share of the premium in one of the following ways:

(1) with after-tax dollars by sending monthly payments to the Employer;

(2) with pre-tax dollars by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the premium the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

(3) under another arrangement agreed upon between the Participant and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold "catch-up" amounts upon the Participant's return).

If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or otherwise required by the FMLA. Open enrollment rights shall be extended to all employees subject to FMLA.

*(b)* *Non-Health Benefits.* If a Participant goes on a qualifying leave under the FMLA entitlement to non-health benefits such as Dependent Care FSA Benefits is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5.

**3.6 Non-FMLA Leaves of Absence**

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be determined by the Administrator. If the Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 9.4 will apply.

**3.7 USERRA**

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under USERRA, the Employer will continue to maintain the Participant's Health Insurance Benefits and Health FSA Benefits on the same terms and conditions as if the Participant were still an active employee, under the same terms, conditions, and options that would apply to a qualifying leave under FMLA, as described in Section 3.4.

## ARTICLE IV
## METHOD AND TIMING OF ELECTIONS

**4.1 Elections**

An Employee who becomes eligible to participate in the Plan and who on such date is a participant in any of the Group Insurance Plans and who is required to make an Employee Contribution thereunder shall be automatically enrolled in the Premium Payment Component on the day such Participant becomes eligible to participate under the Plan to the extent of such Employee Contribution unless the Participant specifically waives such participation during the time period set forth in Sections 4.2 and 4.3 below. Each such Participant shall be presumed to have elected to pay for such Participant's Employee Contributions under the Group Insurance Plans by way of the application of Salary Reductions pursuant to the Premium Payment Component.

Each Participant may elect to participate in the Health Care FSA Component or the Dependent Care FSA Component by electing Salary Reductions and allocating a portion of such Salary Reductions to coverage under the Health Care FSA Component or the Dependent Care FSA Component, or both. Such Participant shall become a participant in the Health Care FSA Component and/or the Dependent Care FSA Component, as applicable, on the effective date of such election

**4.2 Elections When First Eligible**

Elections under the Plan (or waivers of Premium Payment Benefits ) shall be made by submitting an Election Form/Salary Reduction Agreement to the Administrator within 30 days of becoming eligible to participate under the Plan. An Employee who does not elect to participate in the Health Care FSA or Dependent Care FSA Components when first eligible may not enroll until the next Open Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Article IX. If an Employee fails to waive his or her Premium Payment Benefits during the time period set forth, such Eligible Employee's Employee Contributions under the Group Insurance Plans shall automatically be paid by way of the application of Salary Reductions pursuant to the Premium Payment Component.

**4.3 Elections During Open Enrollment Period**

During each Open Enrollment Period with respect to a Plan Year, the Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Components of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election Form/Salary Reduction Agreement must be returned to the Administrator on or before the last day of the Open Enrollment Period. If an Eligible Employee makes an election to participate during an Open Enrollment Period, then the Employee becomes a Participant on the first day of the next Plan Year. If an Eligible Employee fails to waive his or her Premium Payment Benefits during the time period set forth above, such Eligible Employee's Employee Contribution under the Group Insurance Plans shall automatically be paid by way of the application of Salary Reductions pursuant to the Premium Payment Component.

**4.4 Failure of Eligible Employee to File Election Form/Salary Reduction Agreement**

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement pursuant to Section 4.2 by the end of the initial election period, then the Eligible Employee shall be deemed to have elected not to participate in the Plan for the Plan Year in which he or she became eligible to participate in the Plan. If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement pursuant to Section 4.3, the Eligible Employee will be deemed to have elected to continue the same coverages as were in effect during the preceding Plan Year and to the resulting Salary Reductions; provided, however, that an existing Participant's failure to complete an election form pursuant to Section 4.3 by the end of the applicable Open **Enrollment** Period relating to participation in the Health Care FSA Component or the Dependent Care FSA Component shall constitute an election by the Participant to receive his normal Compensation in cash in lieu of such participation for the upcoming Plan Year**.**

**4.5 Irrevocability of Elections**

Unless an exception applies as described in Article IX, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

# ARTICLE V
# BENEFITS OFFERED AND METHOD OF FUNDING

**5.1 Benefits Offered**

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect one or more of the following Benefits:

(a) Premium Payment Benefits, as described in Article VI;
(b) Health FSA Benefits, as described in Article VII; and
(c) Dependent Care FSA Benefits, as described in Article VIII.

In no event shall Benefits under the Plan be provided in the form of deferred compensation.

**5.2 Using Salary Reductions to Make Contributions**

(a) *Salary Reductions per Pay Period.* The Salary Reduction for a pay period for a Participant is, for the Benefits elected, an amount equal to the annual premium for such Benefits (as described in Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, and Section 8.2 for Dependent Care FSA Benefits), divided by the number of pay periods in the Period of Coverage, or an amount otherwise agreed upon between the Employer and the Participant. If a Participant increases his election under the Health FSA Component or Dependent Care FSA Component as permitted under Section 9.4, the Salary Reductions per pay period will be a dollar limit elected less the Salary Reductions made prior to such election change, divided by the number of pay periods in the balance of the Period of Coverage commencing with the election change.

(b) *Considered Employer Contributions for Certain Purposes.* Salary Reductions are applied by the Employer to pay for the premiums for the Premium Payment Benefits, Health FSA Benefits and the Dependent Care FSA Benefits and, for the purposes of this Plan and the Code, are considered to be Employer contributions.

**5.3 Funding this Plan**

All of the amounts payable under this Plan shall be paid from the general assets of the Employer**;** provided, however, that Premium Payment Benefits are paid to the applicable insurance company as provided in the applicable Group Insurance Plan. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets, it may hire an outside paying agent to make Benefit payments on its behalf. The sources of such payments are Salary Reductions by Participants in favor of such benefits.

# ARTICLE VI
# PREMIUM PAYMENT COMPONENT

**6.1 Benefits**

The Group Insurance Benefits that are offered under the Premium Payment Component are group insurance benefits sponsored by the Employer. An Employee who becomes eligible to participate in the Plan and who on such date is a participant in any of the Group Insurance Plans and who is required to make an Employee Contribution thereunder shall be automatically enrolled in the Premium Payment Component **o**n the day such Participant becomes eligible to participate under the Plan to the extent of such Employee Contribution **unless** the Participant specifically waives such participation during the time period set forth in Sections 4.2 and 4.3 above. Unless an exception applies as described in Article **IX**, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**6.2 Benefit Premiums**

The annual premium for a Participant's Premium Payment Benefits shall equal the amount of the Employee Contribution applicable to such Participant under the Group

Insurance Plans. Such amounts shall be applied towards payment of such Participant's Employee Contribution under the Group Insurance Plans.

**6.3 Group Insurance Benefits Provided Under the Group Insurance Plan**

While the election to apply all or a portion of a Participant's Salary Reductions to Premium Payment Benefits under the Group Insurance Plans may be made under this Plan, Group Insurance Benefits will be provided by the Group Insurance Plans, and not this Plan. The types and amounts of Group Insurance Benefits, the requirements for participating in the Group Insurance Plans, and the other terms and conditions of coverage and benefits of the Group Insurance Plans are set forth in the Group Insurance Plans. All claims to receive benefits under the Group Insurance Plans shall be subject to and governed by the terms and conditions of the Group Insurance Plans and the rules, regulations, policies and procedures from time to time adopted in accordance therewith.

# ARTICLE VII
# HEALTH FSA COMPONENT

**7.1 Benefits**

An Eligible Employee can elect to participate in the Health FSA Component by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses, and (b) to pay the premium for such benefits on a pre-tax Salary Reduction basis (Health FSA Benefits). Unless an exception applies as described in Article IX, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**7.2 Benefit Premiums**

The annual premium for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant.

**7.3 Eligible Medical Care Expenses**

Under the Health FSA Component, a Participant may receive reimbursement for Medical Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the medical care.

(b) *Medical Care Expenses.* "Medical Care Expenses" means any expense for medical care within the meaning of the term "medical care" as defined in Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. Medical Care Expenses" shall not include any premium paid for other health benefits coverage, including premiums paid for health benefits coverage under a plan maintained by the employer of a Dependent of the Participant. "Medical Care Expenses" shall also not include any premium paid for long-term care services (as defined in Code Section 7702B(c)). For a sample of eligible and ineligible expenses see Appendix A to this Plan.

**7.4 Maximum and Minimum Benefits**

(a) *Maximum Reimbursement Available: Uniform Coverage.* Reimbursement for Medical Care Expenses of the maximum dollar amount elected by the Participant for a Period of Coverage (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health FSA Account pursuant to Section 7.5. Notwithstanding the foregoing, no reimbursements will be available for expenses incurred after coverage under this Plan has terminated, unless the Participant has elected COBRA as provided in Section 7.8. Payment shall be made to the Participant in cash as reimbursement for Medical Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VII have been complied with.

(b) *Maximum Dollar Limit.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Medical Care Expenses incurred in any Period of Coverage shall be $5,000, subject to Section 7.5 (c) below. The amount will be pro rated to $1,600 for the Short Plan Year. Reimbursements due for Medical Care Expenses incurred by the Participant's Spouse or Dependents shall be charged against the Participant's Health FSA Account.

(c) C*hanges; No Pro-ration.* For subsequent Plan Years, the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Health FSA Component mid-year, or wishes to increase in election mid-year as permitted under Section 9.4, there will be no pro-ration rule—the Participant may elect coverage up to the maximum dollar limit or may increase coverage to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits if Election Change Permitted.* Any change in an election under Article IX affecting annual contributions to the Health FSA Component also will change the maximum reimbursement benefits for the balance of the Period of Coverage commencing with the election change. Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding the contributions made by the Participant (if any) as of the end of the portion of the Period of Coverage immediately preceding the change in election, to the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Health FSA Account(s), reduced by all reimbursements made during the entire Period of Coverage.

**7.5 Establishment of Account**

The Administrator will establish and maintain a Health FSA Account with respect to each Participant who has elected to participate in the Health FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will be merely a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 7.6.

(a) *Crediting of Accounts.* A Participant's Health FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's Health FSA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) *Available Amount Not Based on Credited Amount.* As described in Section 7.4, the amount available for reimbursement of Medical Care Expenses is the Participant's annual benefit amount, reduced by prior reimbursements during the Period of Coverage; it is not based on the amount credited to the Health FSA Account at a particular point in time. Thus, a Participant's Health FSA Account may have a negative balance during a Period of Coverage, but any such negative amount shall never exceed the maximum dollar amount of benefits under this Plan elected by the Participant.

**7.6 Forfeiture of Accounts; Use-It or Lose-It Rule**

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used to pay Plan administrative costs or to offset any Plan losses experienced by the Employer.

**7.7 Reimbursement Procedure**

(a) *Timing.* Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Administrator will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive Health FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, before 90 Days following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth:

(1) the person or persons on whose behalf Medical Care Expenses have been incurred;
(2) the nature and date of the Expenses so incurred;
(3) the amount of the requested reimbursement; and
(4) a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party satisfactory to the Administrator showing that the expense has been incurred and the amount of such Medical Care Expense, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $25.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article X.

**7.8 Reimbursement After Termination; COBRA**

When a Participant ceases to be a Participant under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements. The Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination, provided that the Participant (or the Participant's estate) files a claim within 90 Days following the close of the Plan Year in which the expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents, whose coverage terminates under the Health FSA Component because of a COBRA qualifying event, shall be given the opportunity to continue coverage under the Health FSA Component on an after-tax basis for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). Specifically, such individuals will be eligible for COBRA continuation coverage only if, under Section 7.5, they have a positive Health FSA Account balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if they are eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the year in which the qualifying event occurs; such COBRA coverage for the Health FSA Component will cease at the end of the year and cannot be continued for the next Plan Year.

**7.9 Compliance with ERISA and Laws Applicable to Group Health Plans**

(a) *Named Fiduciary*. Park City School District is the named fiduciary for the Health FSA Component for purposes of ERISA §402(a).

(b) *Laws Applicable to Group Health Plans*. Health FSA Benefits shall be provided in compliance with the following laws to the extent that such laws are applicable to the Health FSA (and the Health FSA is not otherwise exempt or excepted from their terms):

(1) ERISA, including Section 609(a) relating to group health plan coverage pursuant to medical child support orders, and Section 609(b) relating to rights of states with respect to group health plans where participants or beneficiaries are eligible for Medicaid benefits.
(2) COBRA;
(3) HIPAA;
(4) FMLA;

(5) Mental Health Parity Act of 1996, as amended;
(6) Newborns' and Mothers' Health Protection Act of 1996, as amended;
(7) Women's Health and Cancer Rights Act of 1998, as amended;
(8) Uniformed Services Employment and Reemployment Rights Act of 1994, as amended;
(9) Medicare Secondary Payer law, as amended; and
(10) the Code (including the nondiscrimination requirements set forth therein).

(c) *Coordination of Benefits.* Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered a group health plan for coordination of benefits purposes, and Health FSA Benefits shall not be taken into account when determining benefits payable under any other plan.

# ARTICLE VIII
# DEPENDENT CARE FSA COMPONENT

**8.1 Benefits**

An Eligible Employee can elect to participate in the Dependent Care FSA Component by electing to receive benefits in the form of reimbursements for Dependent Care Expenses, and to pay the premium for such benefits on a pre-tax Salary Reduction basis (Dependent Care FSA Benefits). Unless an exception applies as described in Article IX, such election is irrevocable for the duration of the Period of Coverage to which it relates.

**8.2 Benefit Premiums**

The annual premium for a Participant's Dependent Care FSA Benefits is equal to the annual benefit amount elected by the Participant (for example, if the maximum $5,000 annual benefit amount is elected, the annual premium amount is also $5,000).

**8.3 Eligible Dependent Care Expenses**

Under the Dependent Care FSA Component, a Participant may receive reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which an election is in force.

(a) *Incurred.* A Dependent Care Expense is incurred at the time the Qualifying Dependent Care Services giving rise to the expense is furnished, and not when the Participant is formally billed for, charged for, or pays for the Qualifying Dependent Care Services (e.g., services rendered for the month of June are not fully incurred until June 30, and cannot be reimbursed in full until then).

(b) *Dependent Care Expenses.* "Dependent Care Expenses" means expenses that are considered to be employment-related expenses under Code §21(b)(2) (relating to expenses for the care of a Dependent necessary for gainful employment of the Employee and Spouse, if any), and expenses for incidental household services, if paid for by the Eligible Employee to obtain Qualifying Dependent Care Services.

(c) *Qualifying Dependent Care Services.* "Qualifying Dependent Care Services" means the following:

(1) services that both (a) relate to the care of a Dependent that enable the Participant and his or her Spouse to remain gainfully employed after the date of participation in the Dependent Care FSA Component and during the Period of Coverage; and (b) are performed:

(i) in the Participant's home; or
(ii) outside the Participant's home for (a) the care of a Dependent of the Participant who is under age 13; or (b) the care of any other Dependent who regularly spends at least eight hours per day in the Participant's household.

(d) *Exclusion.* Dependent Care Expenses do not include amounts paid to:

(1) an individual with respect to whom a Dependent deduction is allowable under Code §151(c) to the Participant or his or her Spouse;
(2) a dependent care center (as defined in Code §21(b)(2)), unless the requirements of Code §21(b)(2)(c) are satisfied; or
(3) a child of the Participant who is under 19 years of age at the end of the year in which the expenses were incurred.

**8.4 Maximum Benefit**

(a) *Maximum Reimbursement Available: Statutory Limitations.* Payment shall be made to the Participant in cash as reimbursement for Dependent Care Expenses incurred during the Period of Coverage for which the Participant's election is effective, provided that the other requirements of this Article VIII have been complied with. The sum of any Participant's reimbursements for Dependent Care Expenses incurred during any Plan Year shall not exceed the least of:

(1) the Participant's Earned Income for such Plan Year;
(2) the Earned Income of the Participant's Spouse for such Plan Year; or
(3) $5,000, $2,500 if the Participant is married and resides with his or her Spouse but files a separate federal income tax return.

(b) *Maximum Dollar Limit.* The maximum annual benefit amount that a Participant may elect to receive under this Plan in the form of reimbursements for Dependent Care Expenses incurred in any Period of Coverage shall be $5,000 (subject to the other limitations described above, and to Section 8.4(c).

(c) *Changes: No Proration.* For subsequent Plan Years the maximum and minimum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Election Form/Salary Reduction Agreement or another document. If a Participant enters the Dependent Care FSA Component mid-year, or wishes to increase an election mid-year as permitted under Section 9.4, there will be no proration rule—the Participant may elect coverage up to the maximum dollar limit or may increase coverage up to the maximum dollar limit, as applicable.

(d) *Effect on Maximum Benefits if Election Change Permitted.* Any change in an election under Article IX affecting annual contributions to the Dependent Care FSA Component also will change the maximum reimbursement benefits for the

balance of the Period of Coverage (commencing with the election change), as further limited by Section 8.4(a). Such maximum reimbursement benefits for the balance of the Period of Coverage shall be calculated by adding the balance (if any) remaining in the Participant's Dependent Care FSA Account as of the end of the portion of the Period of Coverage immediately preceding the change in election, to the total contributions scheduled to be made by the Participant during the remainder of such Period of Coverage to the Dependent Care FSA Account(s), reduced by reimbursements during the Period of Coverage.

**8.5 Establishment of Account**

The Administrator will establish and maintain a Dependent Care FSA Account with respect to each Participant who has elected to participate in the Dependent Care FSA Component, but it will not create a separate fund or otherwise segregate assets for this purpose. The Account so established will be merely a recordkeeping account with the purpose of keeping track of contributions and determining forfeitures under Section 8.6.

(a) *Crediting of Accounts.* A Participant's Dependent Care FSA Account will be credited periodically during each Period of Coverage with an amount equal to the Participant's Salary Reductions elected to be allocated to such Account.

(b) *Debiting of Accounts.* A Participant's Dependent Care FSA Account will be debited during each Period of Coverage for any reimbursement of Dependent Care Expenses incurred during the Period of Coverage.

(c) *Available Amount is based on Credited Amount.* As described in Section 8.4, the amount available for reimbursement of Dependent Care Expenses may not exceed the year-to-date amount withheld from the Participant's Compensation for reimbursement less any prior reimbursements; it is based on the amount credited to the Dependent Care FSA Account at a particular point in time. Thus, a Participant's Dependent Care FSA Account may not have a negative balance during a Period of Coverage.

**8.6 Forfeiture of Accounts; Use-It or Lose-It Rule**

If any balance remains in the Participant's Health FSA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall not be carried over to reimburse the Participant for Medical Care Expenses incurred during a subsequent Plan Year. The Participant shall forfeit all rights with respect to such balance. All forfeitures under this Plan shall be used to pay Plan administrative costs or to offset any Plan losses experienced by the Employer.

**8.7 Reimbursement Procedure**

(a) *Timing.* The Participant will be reimbursed no later than 30 days following receipt of the Administrator of a completed claim form. The Participant will be reimbursed for Dependent Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who has elected to receive Dependent Care FSA Benefits for a Period of Coverage may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, within 90 Days following the close of the Plan Year in which the Dependent Care Expense was incurred, setting forth:

(1) the person or persons on whose behalf Dependent Care Expenses have been incurred;
(2) the nature and date of the Dependent Care Expenses so incurred;
(3) the amount of the requested reimbursement;
(4) the name of the person, organization or entity to whom the Dependent Care Expense was or is to be paid, and taxpayer identification number (Social Security number, if an individual); and
(5) a statement that such Expenses have not otherwise been reimbursed and are not reimbursable through any other source.

The application shall be accompanied by bills, invoices, or other statements from an independent third party showing the amounts of such Dependent Care Expenses, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement are at least $25.

(c) *Claims Denied.* For reimbursement claims that are denied, see the appeals procedure in Article X.

**8.8 Reimbursements After Termination**

When a Participant ceases to be a Participant as defined under Section 3.2, the Participant's Salary Reductions will terminate, as will the Participant's election to receive reimbursements, subject to the following: such Participant (or the Participant's estate) may claim reimbursement for any Dependent Care Expenses incurred during the calendar month in which such participation ends, provided that the Participant (or the Participant's estate) files a claim before 90 Days following the close of the Plan Year in which the expense arose.

**8.9 Report to Participants**

On or before January 31 of each year, the Administrator shall furnish to each Participant who has received reimbursement for Dependent Care Expenses during the prior calendar year a written statement showing the Dependent Care Expenses paid during such year with respect to the Participant, or showing the Salary Reductions for the year for the Dependent Care FSA Component, as the Administrator deems appropriate, usually a Form W-2.

## ARTICLE IX
## IRREVOCABILITY OF ELECTIONS; EXCEPTIONS

**9.1 Irrevocability of Elections**

Except as described in this Article IX, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding participation in this Plan, Salary Reduction amounts, or election of particular component plan benefits.

**9.2 Procedure for Making New Election if Exception to Irrevocability Applies**

(a) *Timing for When Next Election Must Be Made.* A Participant who is eligible to become a Participant but who, when first eligible under Section 3.1 or during the Open Enrollment Period under Section 3.2, declined to be a Participant, may do so within 30 days of the occurrence of an event described in Section 9.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event, and the election is made within any specified timeframe (e.g., for subsections 9.4(d) through (i), within 30 days of the events described in such subsections).

(b) *Effective Date of Next Election.* Elections made pursuant to this Section 9.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 9.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoptions, all election changes shall be effective on a prospective basis only.

(c) *Effect of New Election Upon Amount of Benefits.* For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and Dependent Care FSA Components, see Sections 7.4 and 8.4, respectively.

**9.3 Change in Status Defined**

A Participant may make a new election upon the occurrence of certain events as described in Section 10.4, including a Change in Status, for the applicable Component of the Plan. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Administrator in its sole discretion, on a uniform and consistent basis, determines are permitted under Internal Revenue Service (IRS) regulations:

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

(b) *Number of Dependents.* Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) *Employment Status.* Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (a) a termination or commencement of employment; (b) a strike or lockout; (c) a commencement of or return from an unpaid leave of absence; (d) a change in worksite; and (e) if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other

employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) *Dependent Eligibility Requirements.* An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) *Change in Residence.* A change in the place of residence of the Participant or his or her Spouse or Dependents

**9.4 Events Permitting Exception to Irrevocability Rule**

(a) *Open Enrollment Period (Applies to Premium Payment, Health FSA and Dependent Care FSA Benefits).* A Participant may change an election during the Open Enrollment Period in accordance with Section 3.2.

(b) *Termination of Employment (Applies to Premium Payment, Health FSA and Dependent Care FSA Benefits).* A Participant's election will terminate under the Plan upon termination of employment in accordance with Section 3.3 and 3.4, as applicable.

(c) *FMLA (Applies to Premium Payment, Health FSA, and Dependent Care FSA Benefits).* A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4.

(d) *Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits, and Dependent Care FSA Benefits as limited below).* A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 9.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the employer of the Participant's Spouse or Dependent. The Administrator in its sole discretion, on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status in a manner satisfying such IRS requirements.

(e) *HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, but Not to Health FSA or Dependent Care FSA Benefits).* If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code §9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right.

(f) *Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to Dependent Care FSA Benefits).* If a judgment, decree, or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's Dependent child (including a foster child who is a Dependent of the

Participant), a Participant may (i) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage), or (ii) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) *Medicare and Medicaid (Applies to Premium Payment and Health FSA Benefits as limited below, but not to Dependent Care FSA Benefits).* If a Participant or his or her Spouse or Dependent who is enrolled in the Premium Payment Component or the Health FSA Component becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the Participant's Premium Payment Benefits or Health FSA Benefits (but such Health FSA Benefits may not be reduced). Further, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the Participant's Premium Payment Benefits or Health FSA Benefits.

(h) *Change in Cost (Applies to Premium Payment and Dependent Care FSA Benefits as limited below, but not to Health FSA Benefits).* For purposes of this Section 9.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For purposes of this definition, a Health FSA is not similar coverage with respect to an accident or health plan that is not a Health FSA. This Plan treats coverage by another employer, such as a Spouse's or Dependent's employer, as similar coverage.

(1) *Increase or Decrease for Insignificant Cost Changes.* Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Options and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Administrator in its sole discretion, on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) *Significant Cost Increases.* If the Administrator determines that the cost charged to an employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option offered by the Employer that provides similar coverage; or (c) drop coverage prospectively if there is no other Benefit Package Option available that

provides similar coverage. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant.

(3) *Significant Cost Decreases.* If the Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, the Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost; and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a cost decrease is significant.

(4) *Limitation on Change in Cost Provisions for Dependent Care FSA Benefits.* The above "Change in Cost" provisions (Sections 9.4 (h)(l)-(3)) apply to Dependent Care FSA Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §152(a)(l) through (8), incorporating the rules of Code §152(b)(l) and (2).

(i) *Change in Coverage (Applies to Premium Payment and Dependent Care FSA Benefits, but Not to Health FSA Benefits).* The definition of "similar coverage" under Section 8.4(h) applies also to this Section 9.4(i).

(1) *Significant Curtailment or Loss of Coverage.* If coverage is "significantly curtailed" Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage or, in the case of a loss of coverage, drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer. Coverage under a plan is deemed "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant" and whether a loss of coverage has occurred.

(2) *Addition or Significant Improvement of a Benefit Package Option.* If during a Period of Coverage, the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Administrator may permit the following election changes: (i) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their election on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (ii) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly

improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether there has been an addition of, or a significant improvement in, a Benefit Package Option.

(3) *Loss of Coverage Under Other Group Health Coverage.* A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program ("SCHIP") under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code §7701 (a)(40)), the Indian Health Service or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) *Change in Coverage Under Another Employer's Plan.* A Participant may make a prospective election change that is on account of and corresponds with a change made under another employer's plan (including a plan of the Employer or a plan of the employer of the Participant's Spouse or Dependent), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations, or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the other employer plan.

(5) *Dependent Care FSA Coverage Changes.* A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

A Participant entitled to change an election as described in this Section 9.4 must do so in accordance with the procedures described in Section 9.2.

**9.5 Election Modifications Required by Administrator**

The Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the

Administrator determines that such action is necessary or advisable in order to (a) satisfy any Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized: (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

# ARTICLE X
# APPEALS PROCEDURE

**10.1 Procedure if Benefits are Denied Under this Plan**

If a claim for reimbursement under this Plan is wholly or partially denied, a written notice of adverse benefit determination shall be furnished to the claimant within a reasonable period of time, not to exceed 30 days after receipt of the claim by the claims official appointed by the Administrator except that this time period may be extended for an additional 15 days for matters beyond the control of the claims official appointed by the Administrator, including in cases where a claim is incomplete.

The claims official appointed by the Administrator will provide written notice of any extension (including the reasons for the extension and the date by which a decision by the claims official appointed by the Administrator is expected to be made) and will allow the Participant 45 days in which to complete an incomplete claim.

The written notice of adverse benefit determination shall be written in a manner to be understood by the claimant and shall include the following:

(a) a specific reason or reasons for the denial;
(b) reference to the specific Plan provision on which the denial is based;
(c) 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
(d) appropriate information as to the steps to be taken if a claimant wishes to appeal the claims official's decision, including the claimant's right to submit written comments and have them considered, the right to review (on request and at no charge) relevant documents and other information, and the right to file suit under ERISA with respect to any adverse determination after appeal of the denied claim.

**10.2 Appeals by Participant**

The purpose of the review procedure set forth herein is to provide a procedure by which a claimant, under this Plan, may have reasonable opportunity to appeal a denial of a claim under this Plan to the Review Panel for a full and fair review. To accomplish that purpose, if a claim is denied in whole or in part, the claimant (or the claimant's duly authorized representative) may request review upon written application to the Review Panel. An appeal must be made in writing within 180 days of the initial notice of adverse

benefit determination from the claims official appointed by the Administrator, or else the claimant will lose the right to appeal the denial.

A claimant's written appeal should state the reasons that the claimant feels the claim should not have been denied. It should include any additional facts and/or documents that the claimant feels supports the claim. The claimant may ask additional questions and make written comments, and the claimant may review (on request and at no charge) documents and other information relevant to the claimant's appeal. The Review Panel will review all written comments submitted with a claimant's appeal.

**10.3 Decision on Review**

Decision on review of a denied claim shall be made in the following manner.

(a) The decision on review of a denied claim shall be made by the Review Panel, which may, in its discretion, hold a hearing on the denied claim; the Review Panel shall make its decision within a reasonable time, but not later than 60 days after the Administrator receives the request for review; and any medical expert consulted in connection with the decision on review will be different from any expert consulted in connection with the initial claim denial. (The identity of a medical expert consulted in connection with the decision on review will be provided.)

(b) If the decision on review affirms the initial denial of the claim, the claimant will be furnished with a notice of adverse benefit determination on review setting forth:

(1) the specific reason(s) for the decision on review;
(2) the specific Plan provision(s) on which the decision is based;
(3) a statement of the claimant's right to review (on request and at no charge) relevant documents and other information;
(4) if the Review Panel relied on an "internal rule, guideline, protocol, or other similar criterion" in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
(5) a statement of the claimant's right to bring suit under ERISA §502(a).

**10.4 Review Panel**

The Administrator may from time to time appoint a Review Panel that may consist of two (2) or more individuals who may, but need not, be Employees. The Review Panel shall review all denied claims to Sections 10.2 and 10.3 above and shall constitute a new reviewing body from the claims official appointed by the Administrator to hear claims pursuant to Section 10.1 above. If no such Review Panel is named, the Administrator shall be deemed to be the Review Panel for purposes of this Article X. The Review Panel shall be the named fiduciary that has the authority to act with respect to any appeal from a denial of benefits or a determination of benefit rights.

# ARTICLE XI
# RECORDKEEPING AND ADMINISTRATION

## 11.1 Administrator

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

## 11.2 Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 11.2, the Review Panel shall exercise such exclusive power with respect to an appeal of a claim under Article X);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan:

(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Plan as the Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

**11.3 Reliance on Participant, Tables, etc.**

The Administrator may rely upon the direction, information or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

**11.4 Provision for Third-Party Plan Service Providers**

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

**11.5 Fiduciary Liability**

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

**11.6 Compensation of Plan Administrator**

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

**11.7 Bonding**

The Administrator shall be bonded to the extent required by ERISA.

**11.8 Insurance Contracts**

The Employer shall have the right (a) to enter into a contract with one or more insurance company for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance company or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

**11.9 Inability to Locate Payee**

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or

whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, including, but not limited to, requesting assistance from the Social Security Administration and/or the Internal Revenue Service, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited if the Participant cannot be located after a period of three (3) months (or such other period determined in a uniform and nondiscriminatory manner by the Company) after the date any such payment first became due.

**11.10 Effect of Mistake**

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Employer from Compensation paid by the Employer.

# ARTICLE XII
# GENERAL PROVISIONS

**12.1 Expenses**

All reasonable expenses incurred in administering the Plan are currently paid by forfeitures to the extent provided in Sections 7.6 and 8.6, and then by the Employer.

**12.2 No Contract of Employment**

Nothing herein contained is intended to be or shall he construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

**12.3 Amendment and Termination**

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

**12.4 Governing Law**

This Plan shall be construed, administered and enforced according to applicable State Law, to the extent not superseded by the Code, ERISA or any other federal law.

**12.5 Code and ERISA Compliance**

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder, (ERISA applies to the Health FSA Component but not to the Dependent Care FSA Component). This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA

shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

**12.6 No Guarantee of Tax Consequences**

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

**13.7 Indemnification of Employer**

If any Participant receives one or more payments or reimbursements under Article VII that are not for Medical Care Expenses, or under Article VIII that are not for Dependent Care Expenses, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

**12.8 Non-Assignability of Rights**

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

**12.9 Headings**

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

**12.10 Plan Provisions Controlling**

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

**12.11 Severability**

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

# Park City School District
# Cafeteria Plan

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Park City School District Cafeteria Plan, Park City School District has caused this Plan to be executed in its name and on its behalf, on this _____ day of _____, 2004.

Park City School District
2700 Kearns Boulevard
Park City, UT 84060
Tax ID: 87-6000509

Signed: _____

Title: _____

Date: _____

# APPENDIX A - HEALTH CARE EXPENSE ACCOUNT - SAMPLE EXPENSES

## Medical Expenses

Acupuncture
Addiction Programs and Products
Adoption (Medical Expenses)
Alternative Healer Fees
Allergy Relief (Oral Medications, Nasal Spray)
Ambulance
Antacids and Heartburn Relief
Arthritis Pain Relieving Creams
Anti-itch and Hydrocortisone Creams
Artificial Limbs
Athlete's Foot Treatment
Body Scans
Care for Mentally Handicapped
Chiropractor
Cold Medicines (i.e. Syrups, Drops, Tablets)
Crutches
Diabetes (i.e. Insulin, Glucose Monitor)
Eye Patches
Fertility Treatment
Fever & Pain Reducers (i.e. Aspirin, Tylenol)
First Aid (i.e. Bandages, Gauze, Creams)
Hearing Aids & Batteries
Hypnosis (For Treatment of Illness)
Incontinence Products (i.e. Depends, Serene)
Joint Support Bandages and Hosiery
Laxatives
Monitoring Device (Blood Pressure, Cholesterol)
Motion Sickness Medication
Physical Exams
Prescription Drugs
Psychiatrist/Psychologist
Physical Therapy
Smoking Cessation Relief (i.e. Patches, Gum)
Speech Therapy
Stomach & Digestive Relief
(i.e. Pepto-Bismol, Imodium, etc.)
Tooth and Mouth Pain Relief (Orajel, Anbesol)
Urinary Pain Relief
Vaccinations
Vaporizers or Humidifiers
Wart Removal Medication
Weight Loss Rx/Programs
Wheelchair

## Dental Expenses

Artificial Teeth
Co-Payments
Deductible
Dental Work
Dentures
Orthodontia Expenses
Preventive Care at Dentist Office
Bridges, Crowns, Etc.


## Vision Expenses

Braille - Books & Magazines
Contact Lenses
Contact Lens Solutions
Eye Exams
Eye Glasses
Laser Surgery
Office Fees
Seeing-Eye Dog and its Upkeep

## What is NOT Eligible

**For Additional Information, Visit www.cafeteriaplan.com**

Health care expenses that do not qualify as a federal income tax deduction under IRS Code Section 213 do not qualify for payment through your expense account. The following list includes many of the common expenses that generally do not qualify for reimbursement.

***These expenses may be eligible if they are prescribed by a physician. (If medically necessary for a specific condition)***

Personal Hygiene (i.e. deodorant, soap, shaving cream, sanitary products, etc.)
Breast Pump (if for convenience)
Cosmetic Surgery
Cosmetics (i.e. makeup, lipstick, cotton swabs, cotton balls, baby oil)
Denture care (i.e. denture cleansers and denture adhesive creams)
Diapers
Exercise Equipment
Hair Care (i.e. hair color, shampoo, conditioner, brushes, hair loss products)
Health Club or Fitness Program Fees
Homeopathic Supplements or Herbs
Household or Domestic Help
Massage Therapy
Maternity Clothes
Nail care & personal grooming (i.e. scissors, nail files)
Nutritional and dietary supplements (i.e. bars, milkshakes, power drinks, Pedialyte)
Routine dental care (i.e. toothpaste, toothbrushes, floss, anti-bacterial mouthwashes, fluoride rinses, breath strips, teeth whitening, etc.)
Skin Care (i.e. sun block, moisturizing lotion, lip balm)
Sleep aids (i.e. oral medications, snoring strips)
Vitamins
Weight reduction aids (i.e. Slimfast, appetite suppressants)