



# **The State of Colorado Salary Reduction Plan**

**For**

**The State of Colorado Employees and Officials**

**Adopted June 1, 1987**

**Amended and Restated July 1, 2018**

## **Article I. Introduction**

### **Section 1.1 Title**

This document shall be entitled, be known as, and be referred to as the “Salary Reduction Plan” (the “Plan”) for the State of Colorado Employees and Officials. The Plan includes all provisions contained hereunder; and is administered by the State of Colorado Department of Personnel & Administration, Division of Human Resources, hereafter referred to as the Plan Administrator.

### **Section 1.2 Scope**

The State of Colorado established the State of Colorado Salary Reduction Plan, effective August 1, 1987 (the “Effective Date”), was first amended and restated effective March 18, 2011 and was last amended and restated effective July 1, 2017 to provide Employees of the State of Colorado the tax savings opportunities permissible under §125 of the Internal Revenue Code of 1986 for:

- a) Employee contributions required under the Employer’s Health Insurance Plan(s); herein referred to as Pre-Tax Premiums;
- b) Contributions to an account for the reimbursement of certain Qualifying Medical Expenses, herein referred to as Health Care Flexible Spending Account;
- c) Contributions to an account for the reimbursement of certain Qualifying Dependent Care Expenses, herein referred to as Dependent Care Flexible Spending Account; or
- d) Any combination of the foregoing, as shall be provided subject to the rules and regulations set forth herein.

This document contains definitions and general administrative provisions that govern the State of Colorado Salary Reduction Plan. The State of Colorado Salary Reduction Plan is intended to qualify as a “Cafeteria Plan” within the meaning of Code §125 and shall be interpreted and administered to accomplish that objective.

## **Article II. Definitions**

### **Section 2.1 Definitions**

The following capitalized words and phrases when used in the text of this Plan and any subsequent amendment, have the meanings set forth below.

“ACA” (Affordable Care Act) refers to the Patient Protection and Affordable Care Act, Public



Law No. 111-148 (March 23, 2010) and the Health Care and Education Reconciliation Act of 2010 (Reconciliation Act), Public Law No. 111-152, and associated Regulations, which comprise federal health care reform.

**“Benefit(s)”** means (a) the Pre-Tax Premium Benefits for the Health Insurance Plan(s), the Health Care Flexible Spending Account Benefits, and the Dependent Care Flexible Spending Account Benefits offered under the Plan, and (b) the services and payment of claims provided Participants enrolled in the Health Insurance Plan(s).

**“Benefit Effective Date”** means the date on which an Employee’s Election becomes effective. In general, the Benefit Effective Date will be the July 1 following the Open Enrollment Period each year. For newly eligible Employees and Dependents, the Benefit Effective Date will be as described in Sections 6.2 and 6.3 of this Plan.

**“Cafeteria Plan”** means a written plan that meets the requirements of Code §125 and offers Participants a choice between cash and certain non-taxable benefits, such as health insurance by which Employees may pay for the benefits they choose on a pre-tax basis.

**“Change in Status”** means any of the events described in Section 7.4.1.

**“Child”** means a Child as defined in the definition of “Dependent”, below.

**“Civil Union Partner”** means a Civil Union Partner as defined in the definition of “Dependent”, below.

**“COBRA”** means the provisions requiring continuation of employer-sponsored group health coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) and incorporated into Title XXII of the Public Health Services Act, 42 U.S. § 300bb-1 – 300bb-8, and associated Regulations.

**“Code”** means and refers to the Internal Revenue Code of 1986, as amended, any successor statute, and associated Treasury Regulations.

**“Compensation”** means wages and salary paid to an Employee by the Employer, determined prior to any Salary Reduction Election under this Plan.

**“C.R.S.”** means the State of Colorado Revised Statutes.

**“Confirmation Notice”** refers to the Participant-specific notice provided subsequent to the Participant’s Election(s) that officially documents the Participant’s Election(s) for the Plan Year. The term includes notices provided in any format, including electronic or online notification.

**“Day”** means calendar day unless otherwise specified.

**“Dependent”** has the meaning given to the term in C. R. S. §24-50-603(5) and (6.5), “Definitions”, as amended and modified or further defined by other Colorado State Statutes (e.g., Title 10) or federal regulations (e.g., Affordable Care Act [ACA], the Code on taxable income), and includes an Employee’s Spouse (as defined in this plan), Civil Union Partner (as defined in this plan), Domestic Partner (as defined in this plan), and Child (as defined in this plan).



The categories of Dependent include:

**A. Current Spouse, including Common Law Spouse:**

1. Spouse means a spouse as recognized under federal tax law.
2. Common Law Spouse means an adult:
  - a. Who is at least 18 years of age; and
  - b. With whom the Employee cohabitates; and
  - c. Who represent themselves to the community as married to each other; and
  - d. There is no legal impediment to the marriage.

**B. Current Civil Union Partner who is an adult:**

1. Eighteen years of age or older who is not under guardianship, unless the party under guardianship has the written consent of his or her guardian to enter into a civil union as created by Article 15 of Title 14, C.R.S.; and
2. Who has entered into a civil union in accordance with the requirement of Article 15 of Title 14, C.R.S. or who has established a relationship legally entered into in other jurisdictions that are similar to civil unions created by Article 15 of Title 14, C.R.S. and that are not otherwise recognized pursuant to Colorado law; and
3. Who is of the opposite gender or same gender as the Employee; and
4. Who is not a party to another civil union; and
5. Who is not married to another person; and
6. Who is not a relative of the Employee.

Article 15 of Title 14, C.R.S. prohibits a person from entering into a civil union with an ancestor, descendant, brother, sister, uncle, aunt, niece or nephew, whether the relationship is by the half or whole blood.

**C. Current Domestic Partner who is an adult:**

1. Who is at least 18 years of age; and
2. Who is of the same gender as the Employee; and
3. With whom the Employee has shared an exclusive, committed relationship with that same person for at least one year prior to enrollment with the intent for the relationship to last indefinitely; and
4. Such relationship was verified by the acceptance of an affidavit of Domestic Partnership by the Department of Personnel and Administration prior to August 8, 2018; and
5. Who is not related to the Employee by blood to a degree that would prohibit marriage; and
6. Neither the Employee nor Domestic Partner is married to another person; and
7. Neither the Employee nor Domestic Partner is in a civil union with another person.

**D. A Child until the end of the month in which the child turns age 26. The legal definition of child must be applied (e.g., first generation, parent-child relationship). As of July 1, 2011, marital status, student status, financial support, and residency are no longer factors under the ACA.**

1. Biological or natural Child.
2. Legally adopted.
3. Legally placed for adoption or foster care.
4. Step-child as long as the Employee and parent are married.
5. Child of a Civil Union Partner.
6. Child of a Domestic Partner as long the Employee and Domestic Partner were in a



committed and verified relationship prior to August 8, 2018.

7. Child for whom the Employee has a court order that specifies responsibility for health insurance coverage (legal custody or allocation of parental responsibility). To qualify for coverage under this provision, a court must determine there is a parent-child relationship for purposes of coverage.

E. A disabled child must be:

1. Unmarried; and
2. Medically certified as disabled prior to the age of 26; and
3. Dependent upon Employee or Spouse/Domestic Partner/Civil Union Partner for financial support; and
4. Proof of disability and dependency must be provided before becoming covered under the Health Insurance Plan(s) annually, if requested; and
5. Newly hired Employees will need to provide proof that the child's disability began prior to the child reaching age 26. If a child of a newly hired Employee or current Employee becomes disabled after the child reaches age 26, the child is ineligible for coverage under the Health Insurance Plan(s).

### **Exclusions**

The following are not entitled to coverage under the Plan except as required by law or court order: Ex-Spouses and their children, Civil Union ex-Partners and their children, same-gender Domestic ex-Partners and their children, opposite-gender Domestic Partners and their children, parents, grandparents and grandchildren, siblings, aunts and uncles, nieces and nephews, cousins, and any other relatives or non-relatives in the household.

Benefits are not provided under this Plan for Dependents who are not Tax Dependents, as defined herein, except, for purposes of coverage under the Health Insurance Plan(s), for a Civil Union Partner or Domestic Partner, who does not qualify as a Spouse, in which case the cost of any benefits will be taxable (unless the individual qualifies as a Tax Dependent of the Employee).

**“Dependent Care Flexible Spending Account” (Dependent Care FSA)** means and refers to the Flexible Spending Account provided for under Article V of this Plan.

**“Director”** means the Executive Director of the Colorado Department of Personnel & Administration.

**“Domestic Partner”** means a Domestic Partner as defined in the definition of Dependent and who was in a committed and documented relationship with the employee prior to the effective date of Colorado Senate Bill 18-131 (SB 18-131), as verified by the acceptance of an affidavit of Domestic Partnership by the Department of Personnel and Administration prior to August 8, 2018.

**“Effective Date”** means August 1, 1987, the original effective date of the Plan; the restated effective date is July 1, 2017.

**“Election”** means and refers to the specific benefit options chosen by a Participant using the Plan's online benefits administration system for a given Plan Year, the level of benefit (e.g., family tier), and the annual Pre-Tax Contribution or other Health Insurance Premium Arrangement designated to fund the benefit. The term includes a choice to waive coverage and any option to which the Participant defaults (e.g., a passive election).



**“Election Form”** refers to the form(s) or means provided by the Plan Administrator for the purpose of allowing (a) an Employee to elect, during the annual Open Enrollment Period, or upon first becoming an Employee, to participate in this Plan; or (b) to change or revoke an Election as provided in Article VII of this Plan. The term includes forms provided in any format, including electronic or online forms under the Plan’s online benefits administration system and any documentation that may be required by the Plan Administrator to verify eligibility.

**“Employee”** has the meaning given to the term in the C.R.S. 24-50-603(7), “Definitions,” as amended, but, for purposes of this Plan, includes only common law employees. Employee does not include persons employed on a temporary basis; except that it shall include a member of the military employed pursuant to C.R.S. 28-3-904 for more than 30 days. For purposes of enrollment in the Health Care FSA, Employee means an employee eligible for medical coverage through the Employer. (Note: The State of Colorado reserves the right to amend or change the definition of Employee because of the ACA requirements).

**“Employer”** means and refers to the State of Colorado. The Colorado Department of Personnel & Administration located at 1525 Sherman Street, Denver, Colorado 80203, has statutory authority for providing benefits to Employees as provided in C.R.S. 24-50- 601 through 24-50-617.

**“Exception to the Irrevocability Rules”** means any of the events and circumstances under which a Participant’s Election may be changed during the Plan Year, in accordance with Article VII of this Plan.

**“Flexible Spending Account”** (FSA) means an account funded with Salary Reductions from which a Participant may be reimbursed for qualifying expenses as provided in §125 of the Code.

**“FMLA”** means the Family and Medical Leave Act of 1993 (Public Law 103-3; 29 U.S.C. sec 2601; 29 C.F.R. 825), as amended, and associated Department of Labor regulations.

**“Health Care Flexible Spending Account”** (Health Care FSA) means the Health Care Flexible Spending Account provided for under Article IV of this Plan. There are two types of Health Care FSAs permitted under the Plan: A General Purpose Health Care FSA that can reimburse all Qualifying Medical Expenses and a Limited Purpose Health Care FSA that can reimburse only dental and vision care expenses (that are not considered medical in nature and cannot be reimbursed by an accompanying High Deductible Health Plan) and post-deductible Qualifying Medical Expenses.

**“Health Savings Account”** (HSA) means a Health Care Savings Account as described in §223 of the Code.

**“Health Insurance Plan(s)”** means the State Employees’ Group Benefits Plans under C.R.S. § 24-50-601. et. seq., maintained by the Employer for its Employees and for the Employees’ Dependents eligible under the terms of such plans, providing health care benefits such as medical, dental and vision care benefits through a group insurance policy or policies or a self- funded arrangement or arrangements.

**“Health Insurance Premium Arrangement”** refers to the options for funding a Participant’s share of Premiums and include: (a) Pre-tax Premiums funded with Salary Reductions; (b) after-tax payroll deductions; and/or (c) personal check or money order, but only when Compensation



is unavailable or insufficient.

**“HIPAA”** refers to provisions of the Health Insurance Portability and Accountability Act of 1996, (Public Law 104-191), 42 U.S.C. § 1320d - 1320d-8, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), and associated Regulations (the “HIPAA Regulations”).

**“High Deductible Health Plan”** or “HDHP” means a health plan that is structured to allow an Employee to participate in a Health Savings Account.

**“IRS”** means the Internal Revenue Service which is a U.S. government agency that operates under the Authority of the U.S. Department of Treasury.

**“Medical Care”** means amounts paid:

(A) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body,

(B) for transportation primarily for and essential to medical care referred to in subparagraph (A),

(C) for qualified long-term care services (as defined in Code section 7702B(c)), or

(D) for insurance (including amounts paid as premiums under part B of title XVIII of the Social Security Act, relating to supplementary medical insurance for the aged) covering medical care referred to in subparagraphs (A) and (B) or for any qualified long-term care insurance contract (as defined in Code section 7702B(b)).

In the case of a qualified long-term care insurance contract (as defined in Code section 7702B(b)), only eligible long-term care premiums (as defined in paragraph (10)) shall be taken into account under subparagraph (D).

**“Open Enrollment Period”** means the limited period prior to the beginning of the Plan Year during which an Employee makes Elections for the next Plan Year and enrolls in the Health Insurance Plan(s) and FSA plans. This period shall be determined on an annual basis by the Plan Administrator and shall end no later than June 1 prior to the beginning of the Plan Year.

**“Participant”** means a common law employee of the State of Colorado who elects to participate and is participating in this Plan in accordance with the provisions of Article VI of this Plan. Participants include those who elect one or more of the Health Insurance Plan Benefits, Health Care FSA Benefits, or Dependent Care FSA Benefits. For purposes of the Health Care FSA, only Employees eligible for Health Insurance Plan Benefits are eligible to enroll in the Health Care FSA.

**“Period of Coverage”** refers to the period of time during the Plan Year to which Benefit Elections apply and for which premiums are required. Services giving rise to claims or requests for reimbursement must be incurred during the Period of Coverage. The Period of Coverage shall commence on the Benefit Effective Date and shall remain in effect for the remainder of the Plan Year. Except as provided in Sections 6.5.3 and 6.5.4 of this Plan for persons on unpaid leave of absence under FMLA or USERRA, and as provided in 6.7 for cancellation of coverage, a Participant’s Period of Coverage shall be uninterrupted during the Plan Year.

**“Plan”** means the State of Colorado Salary Reduction Plan set forth herein and amended from



time to time.

**“Plan Administrator”** means the State of Colorado Department of Personnel & Administration, Division of Human Resources.

**“Plan Year”** means the twelve-month period commencing each July 1 and ending on June 30 of the succeeding calendar year. The initial Plan Year refers to the period from August 1, 1987, to December 31, 1987. There was a short Plan Year for the period commencing January 1, 2005, and ending June 30, 2005.

**“Premium”** means the amount required to be contributed to pay for the cost of Benefits, including self-funded benefits. The term includes premiums contributed after-tax as well as those funded by Salary Reduction and contributed on a pre-tax basis.

**“Pre-Tax Contribution”** means the amount of Salary Reduction authorized and designated by an Employee for contribution to the various accounts included in this Plan.

**“Pre-Tax Premiums”** refers to the amount deducted from Compensation to pay Premiums for coverage under a Health Insurance Plan(s) on a pre-tax basis as provided herein.

**“Protected Health Information” (PHI)** has the meaning given to such term under the HIPAA Privacy Rule, 45 C.F.R. §160.103 and includes information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information on persons living or deceased and includes genetic information under the Genetic Information Nondiscrimination Act of 2008.

**“Qualified Beneficiary”** means any individual, as described in 42 U.S.C. § 300bb-8(3), eligible to continue health care coverage under COBRA as a result of a Qualifying Event.

**“Qualifying Dependent”** under the Dependent Care FSA, means a Dependent who is (a) a Child under age 13 for whom the Employee may claim an exemption under Code §151(c); or (b) a dependent Spouse or other Tax Dependent of the Employee who is physically or mentally incapable of caring for themselves as specified in Code §22(e)(3).

**“Qualifying Dependent Care Expense”** means the expense incurred by a participating Employee for household and dependent care services necessary to enable gainful employment as provided in Code §21(b)(2) in accordance with Code §129.

**“Qualifying Event”** means any event described in 42 U.S.C. § 300bb-3, which gives a Qualified Beneficiary the right to continue health care coverage under COBRA.

**“Qualifying Medical Expense”** means an expense incurred by a participating Employee, Spouse, or Tax Dependent for medical care, as defined in §213(d) of the Code, *excluding* (i) premiums for any Health Insurance Plan(s), policy or contract, or (ii) long-term care expenses as defined in §7702B(c) of the Code, and (iii) any expense which has been reimbursed, or is reimbursable, to such Employee, Spouse, or Tax Dependent from any other source.

**“Qualified Medical Child Support Order (QMCSO)”** is a judgment, decree or court order



that provides for child support or health benefit coverage for a child of an Employee and that satisfies the qualification requirements of §609(a) of Title I of ERISA.

**“Qualified Reservist Distribution”** is a distribution to a Participant who is called to active duty, which meets the requirements of §125(h) of the Code and IRS Notice 2008-82.

**“Regulations”** means the applicable regulations issued under the Code by the IRS, or the Public Health Services Act by the United States Department of Labor or Health and Human Services or any other governmental agency with appropriate authority pursuant to any other applicable federal law, and any rules, notices or releases promulgated by any such authorities.

**“Salary Reduction”** means: (a) the voluntary reduction of an Employee’s Compensation made in consideration of such Employee’s participation in the Pre-Tax Premiums and/or Flexible Spending Accounts pursuant to an Election, and (b) the dollar amount of such reduction.

**“SCHIP”** refers to the State Children’s Health Insurance Program. The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub L. No. 111-3, §311 (2009) created new special enrollment rights for employees and eligible dependents who lose coverage under Medicaid or SCHIP or who become eligible for premium assistance under SCHIP.

**“Similar Coverage”** means coverage for the same category of benefits for the same individuals. Plans offering comprehensive medical insurance coverage (e.g., HMO, POS, PPO) are considered similar coverage, but a Health Care FSA is not similar coverage to any health plan that is not a Health Care FSA and family coverage is not similar to employee-only.

**“Special Enrollment Rights”** means those provisions of Title XXVII of the Public Health Services Act, 42 U.S.C. 300gg, as reflected in Code §9801(f) that require group health plans to provide special enrollment periods during which individuals who previously declined coverage for themselves and their dependents may be allowed to enroll without having to wait until the plan’s next open enrollment period. Special Enrollment Rights do not apply to Flexible Spending Accounts.

**“Special Enrollment Event”** means any of the events described in Section 7.5.1 that trigger Special Enrollment Rights.

**“Spouse”** means a Spouse as defined under the definition of “dependent” above. A Spouse, for this purpose, shall include any Spouse recognized under Federal law.

**“Student”** means an individual who is a full-time student at any educational organization that maintains a regular faculty and curriculum and has an enrolled student body in attendance at the location where its educational activities are conducted.

**“Surviving Dependent”** means the spouse, civil union partner and/or their child (as defined in the definition of Dependent) of an employee who dies in a workplace-related death. A same sex domestic partner and/or their child (as defined in the definition of Dependent) is also included if such relationship was verified by acceptance of an affidavit of Domestic Partnership by the Department of Personnel and Administration prior to the effective date of Colorado Senate Bill 18-131 (SB 18-131), August 8, 2018.

**“Tax Dependent”** means a Dependent for whom the Employee may claim an exemption for



federal tax purposes in accordance with Code §152. For purposes of the Health Insurance Plan(s) and Health Care FSA, the term also includes any Child of the Employee as defined in Code §152 (f)(1) who as of the end of the calendar year has not attained age 27, even if the Child does not otherwise qualify as a Tax Dependent of the Employee.

In accordance with Code §152 (as modified by Code §105(b)(2)) a Civil Union Partner or Domestic Partner will be considered a Tax Dependent for purposes of Articles III and IV of this Plan if the Participant certifies, to the satisfaction of the Plan Administrator, that:

1. The Civil Union Partner or Domestic Partner lives with the Participant and is a member of the Participant's household;
2. The Civil Union Partner or Domestic Partner receives over one-half of his or her support from the Participant;
3. The Civil Union Partner or Domestic Partner is a U.S. citizen, a U.S. national, or a resident of the U.S., Canada or Mexico at some time during the Plan Year; and
4. The Civil Union Partner or Domestic Partner cannot be claimed as a "qualifying child" by someone else. (Generally, a qualifying child is a dependent under age 19 (age 24 if a full-time student) that meets certain IRS requirements).

**"Temporary Basis"** with respect to an Employee is an individual who is appointed to a position or positions for a period not to exceed nine months in any 12-month period. The nine-month limitation shall be inclusive of all temporary appointments and departments. Temporary appointments include appointments to temporary positions, conditional, provisional and substitute appointments.

**"Third-Party Administrator"** (TPA) refers to a contracted entity that performs claims adjudication and other administrative services on behalf of the Plan Administrator.

**"USERRA"** refers to the Uniformed Service Employment and Reemployment Rights Act and associated regulations.

### **Article III. Pre-Tax Premiums**

#### **Section 3.1 General**

The State of Colorado offers contributory, group health insurance coverage for the benefit of its Employees and their Dependents. Such group health insurance coverage is provided by one or more Health Insurance Plan(s). The types and amounts of health insurance benefits, the requirements for participating and the other terms and conditions of coverage and benefits are set forth in the Health Insurance Plan(s) as defined in Section 2.1 of this Plan.

#### **Section 3.2 Benefits**

A Participant may voluntarily pay his or her share of the Premiums for the Health Insurance Plan(s) for the Employee and Tax Dependents on a pre-tax basis by electing Pre-Tax Premiums as provided herein. An Employee who does not prospectively elect the Pre-Tax option will be deemed to have elected to pay for his or her share of the Premiums with after-tax payroll deductions. Unless an Exception to the Irrevocability Rules applies, an Election is irrevocable for the duration of the Period of Coverage. Any Premiums paid by the participant for a Civil Union Partner or Domestic Partner who does not qualify as a Tax Dependent will be paid on an after-tax basis. To the extent such coverage is provided by the Employer to such person without a full



contribution by the Participant, the value of such coverage will be taxable to the Participant.

### **Section 3.3 Funding of Pre-Tax Premiums**

The State of Colorado shall pay the Participant's portion of the Premium for the Health Insurance Plan(s) designated by the Participant using the Plan's online benefit administration system and reduce such Participant's Compensation by the same amount. In addition, the State shall contribute toward the total Premium of the Health Insurance Plan(s) according to the State of Colorado's benefits policies.

### **Section 3.4 Cessation of Employment**

Upon termination of a Participant's employment with the State of Colorado and following issuance of such Participant's final payroll check, no further Pre-Tax Contributions are allowed. Thereafter, continued coverage under one or more Health Insurance Plan(s) is available only as required by COBRA.

## **Article IV. Health Care Flexible Spending Account**

### **Section 4.1 Benefits**

The Health Care FSA is established to allow Participants to pay for certain Qualifying Medical Expenses on a pre-tax basis. It is intended to qualify as a self-insured medical reimbursement plan under Code §105 and the Qualifying Medical Expenses reimbursed hereunder are intended to be eligible for exclusion from a Participant's gross income under Code §105(b). For these purposes, expenses may only be reimbursed for the Participant and individuals who qualify as the Participant's Tax Dependents.

An Employee may voluntarily elect to participate by designating the amount to be contributed to a Health Care FSA using the Plan's online benefit administration system provided by the Plan Administrator. Unless an Exception to the Irrevocability Rules authorized under Article VII applies, the Election is irrevocable for the duration of the Period of Coverage and cannot be revoked, rescinded, or modified.

To the extent a Participant so elects, the Health Care FSA shall be used to pay benefits in the form of reimbursements for Qualifying Medical Expenses, as defined in Section 2.1 of this Plan, incurred during the Period of Coverage, and not otherwise covered or reimbursed from any other source.

This Plan offers two different types of Health Care FSA. Except as otherwise provided by guidance from the U.S. Department of Treasury and the IRS, an Employee may only participate in one of those types of accounts in a given Plan Year. However, the Employee may change such election for a subsequent Plan Year.

- a) A **General Purpose** Health Care FSA permits the reimbursement of any Qualifying Medical Expense. Participation in a General Purpose Health Care FSA will preclude the ability to contribute to a HSA.
- b) A **Limited Purpose** Health Care FSA permits reimbursement only for Qualifying Medical Expenses in relation to dental and vision care (that are not considered medical in nature and cannot be reimbursed by the accompanying High Deductible Health Plan)



and, to the extent permitted by applicable guidance, Qualifying Medical Expenses incurred after the deductible for a High Deductible Health Plan has been met.

**The Employee shall affirmatively elect the type of Health Care FSA in which he or she will participate for the Plan Year.** Notwithstanding the prior sentence, if an Employee elects coverage under the High Deductible Health Plan and is otherwise eligible for an Employer contribution to a Health Savings Account, any election by that Employee to contribute to a General Purpose Health Care FSA shall be changed to an election to contribute to a Limited Purpose Health Care FSA.

#### **Section 4.2 Funding of Health Care Flexible Spending Account**

The State of Colorado shall contribute to each Participant's Health Care FSA the Pre-Tax Contribution designated by the Participant using the Plan's online benefits administration system as a Health Care FSA contribution and shall reduce such Participant's Compensation by the same amount.

#### **Section 4.3 Health Care FSA Maximum and Minimum Contributions**

The maximum amount that may be contributed to the Health Care FSA for any Participant in any Period of Coverage shall be established by the Plan Administrator. The maximum contribution amount for the Health Care FSA for any Plan Year shall be the maximum amount permitted, in accordance with Code § 125(i), as adjusted for any cost of living increase for the year in which such Plan Year begins. This maximum amount is a combined limit that applies to all Health Care FSA sponsored by the Employer.

The minimum contribution amount that may be contributed to the Health Care FSA for any Participant in any Plan Year is \$120.

If a Participant's Pre-Tax Contributions exceed the amount that can be excluded from income, the Participant is responsible for reporting the excess as earned income when filing his or her tax return.

If a Participant is eligible to enroll in the Health Care FSA mid-year or chooses to increase his or her Election mid-year as permitted in the Exceptions to the Irrevocability Rules in Article VII of the Plan, the Participant may elect or increase coverage up to the annual maximum prorated over the remaining months in the Plan Year, as applicable.

#### **Section 4.4 Health Care Flexible Spending Account Benefit Maximum**

Reimbursement of a Qualifying Medical Expense pursuant to Article IV shall be 100% of such expense; however, under no circumstances can the reimbursement to the Participant exceed the annual Pre-Tax Contribution elected for the Plan Year as of the date the expense is incurred. The maximum elected amount shall be available at all times during the Plan Year.

#### **Section 4.5 Payment of Benefits**

In order to claim reimbursement under the Health Care FSA, a Participant must submit with his or her request for reimbursement (claim form) an itemized bill or bills or such other proof as shall be acceptable to the Plan Administrator that such Qualifying Medical Expenses have been incurred



and such other information as the Plan Administrator shall reasonably require to adjudicate the claim, in accordance with IRS Regulations.

The Plan Administrator reserves the right to delegate to a TPA the authority to determine, at its discretion, whether an expense is reimbursable. Each request for reimbursement shall be acted upon and approved or disapproved within forty-five (45) days following its receipt by the TPA. A claim reimbursement must be filed by the deadline in Section 10.2.

The Plan reserves the right to implement a Health Care FSA debit card/electronic card process.

#### **Section 4.6 Forfeiture of Account Balance, “Use it or Lose it” Rule, Qualified Reservist Distributions and Annual Carryover.**

In the event the amount reimbursed to a Participant pursuant to Section 4.5 of this Article IV shall be less than the amount of such Participant’s Pre-Tax Contribution after all reimbursements have been made for a Period of Coverage, the Participant shall forfeit all rights to such Health Care FSA balance, except as provided below.

In accordance with federal Section 125 Regulations, the balance shall not be applied to any other account, forfeited balances shall be used by the Employer first to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursement to any Participant in excess of the Contributions paid by such Participant, second to reduce the Employer’s reasonable administrative expenses for administering the Plan, and third to reduce Premiums or increase coverage to Participants in the following Plan Year in the manner the Employer deems appropriate.

**Qualified Reservist Distribution:** A Participant, in accordance and consistent with IRS Notice 2008-82, may receive a Qualified Reservist Distribution of the Participant’s Health Care FSA balance if:

- a) such Participant was a member of a reserve component ordered or called to active duty for a period in excess of 179 days or an indefinite period; and
- b) such distribution is made during the period beginning on the date of such order or call and ending on the last date that reimbursements could be made.

A Qualified Reservist Distribution may not be made based on an order or call to active duty of an individual other than the Participant, including the Spouse of the Participant.

Such a Participant may make Health Care FSA claims for medical expenses incurred before the date a Qualified Reservist Distribution is requested. For purposes of this paragraph, the amount eligible for the Qualified Reservist Distribution is the entire amount contributed to the Health Care FSA for the Plan Year minus Health Care FSA reimbursements received as of the date of the distribution request. The Participant shall not have the right to submit claims for medical expenses after the date of the distribution.

**Carryover Provision:** A Participant may carry over, at the Participant’s option, to the immediately following Plan Year, up to \$500 of any amount remaining unused as of the end of the Plan Year in a Health Care FSA. The carryover of up to \$500 may be used to pay or reimburse medical expenses under the Health Care FSA incurred during the entire Plan Year to which it is carried over. The carryover may be repeated year after year. An employee may opt out of this carryover provision by completing an opt out form available from the Health Care FSA TPA. For this purpose, the amount



remaining unused as of the end of the Plan Year is the amount unused after medical expenses have been reimbursed at the end of the Plan's run-out period for the Plan Year.

To the extent permitted by applicable guidance, a Participant may apply the carryover to the other type of Health Care FSA. For example, if in one year, the Participant elected to contribute to a General Purpose Health Care FSA, but in the following year, the Participant qualifies to contribute to an HSA, up to \$500 of the Participant amounts left over in the General Purpose FSA can be carried over to a Limited Purpose FSA.

In addition to the unused amounts of up to \$500, a Participant may also elect up to the maximum annual allowed salary reduction amount under §125(i). In accordance with law, this State of Colorado Salary Reduction Plan **does not have a grace period** in addition to a carryover provision.

Any unused carryover shall be forfeited one full Plan Years after the end of the Plan Year in which such carryover was created, provided the Participant who created the carryover does not make an election to contribute a Health Care FSA under this Plan for that one full Plan Year. This rule shall only apply to Participants who remain Employees during such period and is not meant to override "use it or lose it" rule of Section 5.6.

#### **Section 4.7 Cessation of Participation**

An Employee who ceases to be a Participant in the Health Care FSA for any reason shall be entitled to continue receiving reimbursements for Qualifying Medical Expenses, but only for expenses incurred during the Period of Coverage and prior to the date the Employee ceased to be a Participant. Participation in the Health Care FSA may be continued until the end of the Plan Year under the continuation of coverage provisions in Article X. Any claim for reimbursement must be filed by the deadline in Section 10.2.

#### **Section 4.8 Medical Care Expenses**

For purposes of this Article IV, medical care expenses means expenses permitted under Code § 213(d), which include amounts paid for the purchase of medical services, prescription drugs, insulin, medical supplies, over-the-counter drugs or medicines when accompanied by a prescription. The expenses must be primarily to alleviate or prevent a physical or mental defect or illness. Expenses for solely cosmetic reasons and expenses that are merely beneficial to one's general health are not expenses for medical care. Only medical care expenses that are also Qualifying Medical Expenses, as defined in Section 2.1 of the Plan, incurred during the Period of Coverage, are reimbursable from the Health Care FSA. An expense is incurred at the time the service giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the service.

Notwithstanding the previous paragraph, the Plan will reimburse Participants for orthodontia services before the services are provided but only to the extent that the Participant has actually made the payments in advance of the orthodontia services in order to receive the services. These orthodontia services are deemed to be incurred when the Participant makes the advance payment.

In the case of a General Purpose Health Care FSA, all Qualifying Medical Expenses can be reimbursed. In the case of a Limited Purpose Health Care FSA, only Qualifying Medical Expenses for dental and vision care may be reimbursed until the Employee meets the applicable deductible



under a High Deductible Health Plan.

#### **Section 4.9 Limitations**

Notwithstanding any other provision contained herein, Qualifying Medical Expense shall not include any amount that is not excluded from income pursuant to Code §105. For purposes of this Plan, any IRS published ruling position shall be considered determinative of the question whether a particular Qualifying Medical Expense is excluded from income under Code §105, unless that position has been overturned by either the IRS or a court with appropriate jurisdiction. Only expenses incurred during a Plan Year in which the Employee is a Participant shall be covered under the Plan.

#### **Section 4.10 Statements**

The Plan Administrator shall make available to each Participant, periodic statements during the Plan Year, according to a schedule established by the Plan Administrator, showing contributions credited to and reimbursements paid from such Participant's Health Care FSA.

### **Article IVa. Health Savings Accounts (HSA)**

#### **Section 4a.1 Employee Deferrals**

At the time the Employer is in a position to administratively process and decides to permit Employee contributions, eligible Participants shall be permitted to contribute on a pre-tax basis to a HSA. A Participant will be considered eligible for such a contribution if such Participant's only health care coverage is a High Deductible Health Plan as defined in Code §223(c)(2). Such Participant HSA contributions, along with any contributions made by the Employer to the HSA, shall be subject to the rules and limitations of Code §125, 223 and 4980G, including the nondiscrimination and comparable contributions rules, if applicable.

Unlike other provisions of this Plan, the mandatory 12-month period of coverage shall not apply to HSA contributions. Additionally, a Participant shall only be entitled to reimbursements for any expenses that do not exceed the amount in the Participant's HSA.

Until such time as Employee contributions are permitted under the Plan, any Employer contribution to an HSA will be considered to be made outside of this Plan.

### **Article V. Dependent Care Flexible Spending Account**

#### **Section 5.1 Benefits**

The Dependent Care FSA is established to allow Participants to pay for certain Qualifying Dependent Care Expenses on a pre-tax basis. It is intended to qualify as a dependent care assistance program under §129 of the Code.

An Employee may voluntarily elect to participate by designating the amount to be contributed to a Dependent Care FSA using the Plan's online benefits administration system provided by the Plan Administrator. Unless an Exception to the Irrevocability Rules authorized under Article VII applies, the Election is irrevocable for the duration of the Period of Coverage.



To the extent a Participant so elects, the Dependent Care FSA shall be used to pay benefits in the form of reimbursements for Qualifying Dependent Care Expenses, as defined in Section 2.1 of this Plan, incurred during the Period of Coverage, and not otherwise covered or reimbursed from any other source.

## **Section 5.2 Funding of Dependent Care FSA**

The Employer shall contribute to each Participant's Dependent Care FSA the Pre-Tax Contribution designated by the Participant using the Plan's online benefits administration system and shall reduce such Participant's Compensation by the same amount.

## **Section 5.3 Dependent Care FSA Maximum and Minimum Contributions**

The maximum contribution to the Dependent Care FSA that may be contributed, excluded and reimbursed from income for any Participant in any calendar year is \$5,000 (\$2,500 if the Participant is married and filing a separate return). The amount payable may not be greater than the amount of the Participant's earned income or the earned income of his or her Spouse, if married.

If a Participant's pre-tax contributions exceed the amount that can be excluded from income, the Participant is responsible for reporting the excess as earned income when filing their tax return.

For purposes of this Section 5.3, earned income means earned income as defined in §32(c)(2) of the Code and includes, (i) wages, salaries, tips, and other employee compensation, plus (ii) net earnings from self-employment (within the meaning of §1402(a) of the Code) but determined without regard to the deduction allowed by §164(f) of the Code, and (iii) amounts deemed earned income under Article V, Section 5.10 Special Rules. Earned income shall not include any amounts paid to the Participant by the State of Colorado for employment related expenses.

With regard to item 5.3(b) of this Section 5.3, the earned income of only the Spouse to whom the Employee is married at the close of the calendar year is taken into account (and not the earned income of another Spouse who died or was divorced from the Employee during the calendar year). The Spouse's earned income for the entire calendar year is taken into account, even though the Employee and his or her Spouse were married for only a part of the calendar year.

If a Participant is eligible to enroll in the Dependent Care FSA mid-year or chooses to increase his or her Election as permitted under the Exception to Irrevocability Rules in Article VII of this Plan, the Participant may elect or increase coverage up to the maximum limit provided in this section prorated over the remaining months in the Plan Year.

The minimum amount that may be contributed to the Dependent Care FSA for any Participant in any Plan Year is \$120.

## **Section 5.4 Dependent Care FSA Benefit Maximum**

Reimbursement of a Qualifying Dependent Care Expense pursuant to Article V shall be 100% of such Qualifying Dependent Care Expense, not to exceed the balance in the Dependent Care FSA of a Participant at any given time. Under no circumstances can the reimbursement to the Participant exceed the annual Pre-Tax Contribution to the Dependent Care FSA elected for the Plan Year as of the date the expense is incurred.



### **Section 5.5 Payment of Benefits - Substantiation**

In order to claim reimbursement under the Dependent Care FSA, a Participant must be able to substantiate expenses and eligibility. A Participant must submit with his or her request for reimbursement (claim form) an itemized bill or bills or such other proof as shall be acceptable to the Plan Administrator that such Qualifying Dependent Care Expenses have been incurred and such other information as the Plan Administrator shall reasonably require to adjudicate the claim, including necessary information from the dependent care provider on the nature of services rendered. Such bills or proof of Qualifying Dependent Care Expense must show the date the expense was incurred as well as the amount. The Plan Administrator may require each Participant claiming reimbursement to submit the name, address, Social Security number or taxpayer identification number of the person providing the services to which such Qualifying Dependent Care Expenses are attributable.

The Plan Administrator reserves the right to delegate to a TPA the authority to determine, at its discretion, whether an expense is reimbursable as a Qualifying Dependent Care Expense. Each request for reimbursement shall be acted upon and approved or disapproved within forty-five (45) days following its receipt by the claims adjudicator. Claims must be filed by the deadline in 10.2.

### **Section 5.6 Forfeiture of Salary Reduction, "Use it or Lose it" Rule.**

In the event the amount reimbursed to a Participant pursuant to Section 5.5 of this Article V shall be less than the amount of such Participant's Pre-Tax Contribution to the Dependent Care FSA after all reimbursements have been made for a Period of Coverage, the Participant shall forfeit all rights with respect to such balance. In accordance with federal cafeteria plan Regulations, the balance shall not be applied to any other account, carried over to a subsequent Plan Year nor refunded to the Participant.

Forfeited balances shall be used by the Employer first to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursement to any Participant in excess of the Contributions paid by such Participant; second to reduce the Employer's reasonable administrative expenses for administering the Plan, and third to reduce Premiums, provide a refund or increase coverage to Participants in the following Plan Year in the manner the Employer deems appropriate.

### **Section 5.7 Cessation of Participation**

An Employee who ceases to be a Participant in the Dependent Care FSA for any reason, shall be entitled to continue receiving reimbursement for Qualifying Dependent Care Expenses, but only to the extent of the amount credited to his or her Dependent Care FSA as of the date the Employee ceases to be a Participant, and only for Qualifying Dependent Care Expenses incurred on or prior to the end of the Period of Coverage.

### **Section 5.8 Dependent Care Expenses**

To be reimbursable under this Plan, Qualifying Dependent Care Expenses must be:

- a) for the care of a Qualifying Dependent as defined in Section 2.1 of this Plan;
- b) limited to the household and dependent care services necessary for gainful employment



- as provided in Code §21(b)(2) in accordance with Code §129;
- c) not reimbursed or reimbursable through insurance or any other plan;
- d) incurred after the Benefit Effective Date and prior to the end of the Period of Coverage; and
- e) if expenses are incurred for services provided by a licensed dependent care center, the center must comply with all applicable state and local laws and regulations.

A Qualifying Dependent Care Expense is incurred at the time the service giving rise to the expense is furnished, not when the Participant is formally billed for, is charged for, or pays for the service (e.g., services for the month of July are not fully incurred until July 31 and cannot be reimbursed in full until then.)

### **Section 5.9 Limitations**

Notwithstanding any other provision contained herein, no reimbursements shall be allowed for any amounts paid to an individual for Dependent Care:

- a) who is the Spouse of the Employee;
- b) for whom a personal exemption is allowable under Code §151(c) either to the Employee or the Spouse for the year; or
- c) who is a child or stepchild of the Employee who is under the age of 19 at the close of the Plan Year in which the expenses were incurred.

An amount that may constitute an expense otherwise deductible by the Participant under Code §213 (relating to health expenses) or reimbursable as a health expense under other Articles of this Plan will not constitute a Qualifying Dependent Care Expense reimbursable under this Article V to the extent that the Participant claims such deduction on his or her federal income tax return or to the extent that such amount is actually reimbursed to the Participant as a health care expense.

Eligible Expenses shall not include any amount that is not excludable from income pursuant to Code §129. For purposes of this Plan, any IRS published ruling position shall be considered determinative of the question whether a particular Qualifying Dependent Care Expense is excluded from income under Code §129, unless that position has been overturned by either the IRS or a court with appropriate jurisdiction.

### **Section 5.10 Special Rules**

#### **Section 5.10.1 Student Spouses**

For purposes of this Article V, in the case of a Spouse who is a student, that Spouse shall be deemed, for each month during which he or she is a full-time student at an educational institution, to be gainfully employed and to have earned income of not less than:

- a) \$250 if there is one Eligible Dependent with respect to the Employee, or
- b) \$500 if there are two or more Eligible Dependents with respect to the Employee.
- c) In the case of any husband and wife, this Section 5.10.1 (a) and (b) shall apply with respect to only one Spouse for any one month.



### **Section 5.10.2 Gainful Employment**

For purposes of this Article V, in the case of a Spouse who is incapable of caring for him or herself, that Spouse shall be deemed, for each month during which he or she is incapable of caring for him or herself, to be gainfully employed and to have earned income of not less than:

- a) \$250 if there is one Eligible Dependent with respect to the Employee, or
- b) \$500 if there are two or more Eligible Dependents with respect to the Employee.
- c) In the case of any husband and wife, this Section 5.10.2 (a) and (b) shall apply with respect to only one Spouse for any one month.

### **Section 5.11 Allocation of Expenses**

Where a portion of an expense is for household services or for the care of an Eligible Dependent and a portion of such expense is for other purposes, a reasonable allocation must be made and only the portion of the expense that is attributable to such household services or care is considered to be a Qualifying Dependent Care Expense. No allocation is required to be made, however, if the portion of expense for the other purpose is minimal or insignificant.

### **Section 5.12 Statements**

The Plan Administrator shall furnish to each Participant, periodic statements during the Plan Year, according to a schedule established by the Plan Administrator, showing contributions credited to and reimbursements paid from such Participant's Dependent Care FSA.

## **Article VI. Eligibility and Enrollment**

### **Section 6.1 Eligibility**

All Employees of the State of Colorado, as defined in Section 2.1, are eligible for participation in this Plan during the time of their employment, subject to the provisions in this Article VI. Only Employees eligible to enroll in the Health Insurance Plan may enroll in the General Purpose Health FSA.

### **Section 6.2 Enrollment in the Plan**

Employees who wish to participate in the Plan must enroll within the limited time period allotted for enrollment in accordance with the policies and procedures established by the Plan Administrator. Employees who fail to timely make an election using the Plan's online benefits administration system will not be permitted to enroll in the Plan until the next Open Enrollment Period, unless an Exception to the Irrevocability Rules authorized under Article VII applies.

#### **Section 6.2.1 Open Enrollment**

During the regularly scheduled Open Enrollment Period and prior to the commencement of the Plan Year, eligible Employees may:

- a) Elect to fund Health Insurance Plan(s) Premiums with Salary Reductions by prospectively designating the Pre-Tax Premium option of the chosen plan(s);



- and/or
- b) Elect to fund Health Insurance Plan(s) Premiums on an after-tax basis by prospectively designating the after-tax option; and/or
  - c) Elect to participate in the General Purpose or Limited Purpose Health Care FSA and/or Dependent Care FSA by prospectively designating amounts to be contributed to each account; and/or
  - d) Elect not to participate in the Health Insurance Plan(s) or the Health Care FSA and/or Dependent Care FSA plans by actively waiving participation.

Employees who do not make an election during open enrollment will be deemed to have elected to waive coverage, except that, during any period when automatic enrollment for health insurance benefits is required under any applicable law or laws, will be deemed to have elected the default plan option designated by the Plan Administrator with premiums paid for with after-tax contributions.

Elections will be effective on the first day of the next Plan Year provided a proper election is made using the online benefits administration system within the allotted time period, and unless an Exception to the Irrevocability Rules authorized in Article VII applies, shall be irrevocable for the Plan Year.

### **Section 6.2.2 New Employees**

New benefits eligible Employees may elect Health Insurance Coverage, Pre-Tax Premiums and/or establish Health Care FSA and Dependent Care FSA within thirty-one (31) days of their date of hire or initial eligibility. Employees who do not make an election within thirty-one (31) days of their date of hire or initial eligibility will be deemed to have elected to waive coverage, except that, in the case of health insurance benefits during any period when automatic enrollment for health insurance benefits is required under any applicable law or laws, Employees will be deemed to have elected the default plan option designated by the Plan Administrator with premiums paid with after-tax contributions. The first day of the 31-day period is the day after the date of hire or initial eligibility, if later.

Elections made by new benefits eligible Employees shall be effective the first of the month following their date of hire provided that a properly completed Election Form is submitted within the allotted time period, and unless an Exception to the Irrevocability Rules authorized under Article VII applies, the Election is irrevocable for the duration of the Period of Coverage.

### **Section 6.3 Special Enrollment Rights**

An Employee who elects Health Insurance coverage, pursuant to Special Enrollment Rights as referenced in Section 7.5.1, may enroll within thirty-one (31) days of the event giving rise to the Special Enrollment, except that Employees and/or Dependents who lose coverage under Medicaid or SCHIP or who become eligible for premium assistance under Medicaid or SCHIP have sixty (60) days in which to enroll.

Elections made by such Participants shall be effective the first of the month following the date a proper election is made using the Plan's online benefits administration system, except that newborn and adopted children shall be covered as of the date of birth, adoption or placement for adoption provided that a timely online election is submitted within thirty-one (31) days of such



birth, adoption, or placement. Premiums shall be payable from the first of the month following the date of birth, adoption or placement for adoption. Special Enrollment Rights do not apply to the Dependent Care FSA.

#### **Section 6.4 Renewal**

A new Election is required each Plan Year for participation in this Plan, except that when there are no significant changes to the Health Insurance Plan(s) provisions or Premiums, the Plan Administrator, may by written directive, permit passive enrollment in the Health Insurance Plan(s), in which case a Participant's Health Insurance Election and Pre-Tax Premium Election will be renewed automatically during the regularly scheduled annual Open Enrollment Period unless the Participant actively waives coverage or elects a different option.

Health Care FSA and Dependent Care FSA *cannot* be automatically renewed. A new Election is required each Plan Year for participation in the Health Care FSA and Dependent Care FSA.

#### **Section 6.5 Leave of Absence**

A Participant granted certain authorized leaves of absence under the policies prescribed by the State, will be eligible to continue coverage in accordance with the following provisions.

##### **Section 6.5.1 Paid Leave of Absence**

An Employee on paid leave of absence will continue participation in the Plan and be deemed to have no change in his or her employment or eligibility to continue to participate in the Plan. However, expenses for dependent care incurred during such a leave may not, in all cases, qualify as Qualifying Dependent Care Expenses under the Dependent Care FSA, including expenses that are not work related as specified in the Code.

##### **Section 6.5.2 General Unpaid Leave of Absence**

An Employee on unpaid leave of absence, including FMLA and USERRA, may continue participation in the Plan by paying the applicable Premiums during the leave pursuant to Section 6.5.5. However, expenses for dependent care incurred during such leave may not, in all cases, qualify as Eligible Expenses under the Dependent Care FSA.

##### **Section 6.5.3 Unpaid Leave Under the FMLA**

If a Participant takes unpaid leave under the FMLA, to the extent required by the FMLA, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Employee.

A Participant who loses Benefits coverage during a period of unpaid FMLA leave (e.g., for non-payment of required contributions), shall have his or her Benefits coverage reinstated following his or her return from such leave at the same level or levels in effect immediately prior to taking of the leave, providing the Participant returns from leave during the same Plan Year in which he or she left. However, Benefits are not payable for expenses incurred during any period for which Premiums are not paid.

With regard to participation in the Health Care FSA, a Participant whose coverage ceased



shall be reinstated in the Health Care FSA at the same coverage level as in effect before the FMLA leave (with increased Pre-Tax Contributions for the remaining Period of Coverage), or upon written request submitted within 31 days of returning to active employment, at a coverage level that is reduced pro-rata for the period of FMLA leave during which the Participant did not make Pre-Tax Contributions.

#### **Section 6.5.4 Unpaid Leave Under USERRA**

A Participant who loses coverage during a period of qualified military duty under USERRA lasting more than thirty-one (31) days and who becomes reemployed with the State within the required time period, shall have his or her Benefits reinstated following his or her return from such leave at the same level or levels in effect immediately prior to taking of the leave, providing the Participant returns from leave during the same Plan Year in which he or she left. However, Benefits are not payable for expenses incurred during any period for which Premiums are not paid.

With regard to participation in the Health Care FSA, a Participant whose coverage ceased shall be reinstated in the Health Care FSA at the same coverage level as in effect before the USERRA leave (with increased Pre-Tax Contributions for the remaining Period of Coverage), or upon written request submitted within 31 days of returning to active employment, at a coverage level that is reduced pro-rata for the period of USERRA leave during which the Participant did not make Pre-Tax Contributions.

#### **Section 6.5.5 Payment Options during Unpaid Leave**

A Participant who continues coverage under the Plan while on unpaid leave of absence may choose from one of the following payment options.

- a) *Pre-pay Option.* Participants may pay, prior to the commencement of the leave period, the amounts of Premiums and Pre-Tax Contributions otherwise due for the leave period. Premiums and contributions under the pre-pay option may be made on a pre-tax salary reduction basis from any available Compensation. Premiums and contributions under the pre-pay option may also be paid by check or money-order.
- b) *Pay-as-you-go option.* Participants may make monthly Premium payments and contributions by check or money-order.

Such Premiums and/or contributions shall be due and payable by the first of the month in advance, except that Premiums and contributions due during a period of FMLA leave or military leave under USERRA are payable on the same schedule as would be made if the Participant were not on leave.

Benefits coverage will be terminated for any Participant who fails to make the required Premium payments and/or contributions when due, subject to any grace period that may be required by rule or Regulation. The State of Colorado is entitled to recover Premiums paid on behalf of a Participant (e.g., during any grace period) to the maximum extent permitted by law.



## **Section 6.6 Absence Due to Disability**

A Participant absent from work due to a disability (i) who is receiving Compensation from which Salary Reductions can be made shall continue to participate in the Plan until the earlier of the end of the Plan Year in which the disability occurred or the date he or she ceases to receive such Compensation; or (ii) who is not receiving such Compensation or who ceases to receive such Compensation during the Plan Year shall continue to participate in the Plan on the same basis as provided for general unpaid leave of absence in Section 6.5.2 of this Article VI.

## **Section 6.7 Cancellation of Coverage**

### **Section 6.7.1 Cessation of Required Contributions By A Participant**

If a Participant does not make the required Premium or Salary Reduction payments when due during a Plan Year, either prior to or after a separation from service, the Benefit coverage under this Plan will cease and the Participant will not be allowed to make a new Election for the remainder of that Plan Year, except as provided in Section 6.5.3 as required under FMLA and Section 6.5.4 as required by USERRA. The Employer is entitled to recover Premiums for any Period of Coverage for which the Employer paid the Employee's share of the Premium (e.g., during the grace period) to the maximum extent permitted by law.

### **Section 6.7.2 Separation from Service**

Upon termination of a Participant's employment with the State of Colorado, Salary Reduction will cease. However, benefits will continue to be available for reimbursement upon receipt of a valid claim for Qualifying Health Care Expenses incurred prior to such termination and for Qualifying Dependent Care Expenses incurred prior to the end of the Period of Coverage.

Participants who wish to continue Health Insurance Plan(s) coverage (including Health Care FSA) under COBRA may do so on an after-tax basis, subject to the provisions set forth in Article X of this Plan in accordance with federal COBRA regulations. A Dependent Care FSA cannot be continued under COBRA.

A Participant who terminates participation due to separation from service and then returns to the employ of the State within thirty-one (31) days during the same Plan Year shall not be considered to have experienced a Qualifying Event or Change in Status, thus, shall have participation in the Plan reinstated upon return to employment with no change of coverage or Election.

A Participant who terminates employment, and then returns to the employ of the State in a benefits eligible position more than thirty-one (31) days later during that same Plan Year, will be allowed to make a new Election, except that if such individual continues coverage under the Health Insurance Plan(s) or Health Care FSA under COBRA during the period between termination and return to employment, his or her active participation shall be reinstated with no change of coverage or Election.



## **Article VII. Election Changes**

### **Section 7.1 Irrevocability of Elections**

Except as provided in this Article VII, Elections made with respect to the Health Insurance Plan(s), Pre-Tax Premiums, Health Care FSA, and Dependent Care FSA as established under Articles III, IV and V are irrevocable and shall remain in effect for the entire Plan Year (or in the case of a new Participant, for the remainder of that Plan Year).

### **Section 7.2 Mid-Year Election Changes**

During the Plan Year, a Participant may make a new Election upon the occurrence of certain events as described in this Article VII, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS Regulations and under this Plan.

The Participant seeking a change of Election must be able to substantiate the circumstances permitting such change by providing sufficient evidence as may be required by the Plan Administrator, including necessary information from another group insurance plan, employer, or service provider.

### **Section 7.3 Procedure for Making New Election if Exception to Irrevocability Applies**

A Participant may make a new Election under circumstances described in Sections 7.4 and 7.5 of this Article VII, as applicable, but only if the Participant submits a new online election within thirty-one (31) days of the event along with documentation that the Plan Administrator deems necessary to verify that the change is permissible under the Plan. (For these purposes, the thirty-one (31) day period begins the day after the occurrence of the event giving rise to the new Election.) Documentation, satisfactory to the Plan Administrator that the event occurred must be submitted within forty-five (45) days after the day of the event. If the event is a change of eligibility for Medicaid or SCHIP as described in Section 7.5.1 (c)(d) of this Article VII, the Participant will be allowed sixty (60) days in which to submit a new Election.

Except as provided in Section 7.5.1 for HIPAA Special Enrollment Rights in the event of birth, adoption or placement for adoption, **all Election changes shall be effective on a prospective basis only**, i.e., no earlier than the first of the month following submission and approval of a properly completed election using the Plan's online benefits administration system.

### **Section 7.4 Exceptions to the Irrevocability Rules - Change in Status**

With regard to Pre-Tax Premiums, coverage under a Health Insurance Plan(s), Health Care FSA or Dependent Care FSA, a Participant may revoke a prior Election and make a new prospective Election **if the requested change is on account of and consistent with a corresponding Change in Status event**, as described in Section 7.4.1 and the Change in Status event affects eligibility for coverage.

The Plan Administrator reserves the right to determine, at its discretion, based upon IRS guidance, whether a change of Election is on account of and consistent with the Change in Status event.



### Section 7.4.1 Change in Status Defined

With regard to Section 7.4, each of the following events is a Change in Status, **but only if it affects eligibility for Benefits under the Plan or the plan of another employer.**

A change in a Participant's legal marital status, including marriage, death of Spouse, divorce, legal separation, and annulment.

- a) Events that change a Participant's number of Tax Dependents, including birth, death, adoption, and placement for adoption.
- b) Any of the following events that change the employment status of the Participant or his or her Spouse or Tax Dependents: (i) a termination or commencement of employment; (ii) a strike or lockout; (iii) a commencement of or return from an unpaid leave of absence under FMLA or USERRA; (iv) changing from or to temporary and permanent employment, or (v) a change in worksite.
- c) Events that cause a Participant's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age.
- d) Change in the Employee's place of residence.

A Participant may elect to change coverage options on the occurrence of one of the events described in this Section 7.4.1, as permitted under IRS guidance.

### Section 7.4.2 Specific Consistency Requirements

If a Participant's new Election fails to be on account of and consistent with the Change in Status, the change shall not be permitted, as illustrated in this Section 7.4.2.

- a) *Loss of Spouse or Dependent Eligibility (e.g., due to death, change of marital status, or attainment of limiting age).* If a Dependent ceases to satisfy the eligibility requirements of a Health Insurance Plan(s), a Participant may elect to cancel coverage for only the Dependent that ceased to satisfy the eligibility requirements. An Election to cancel or reduce coverage for any other individual under these circumstances would fail to correspond with that Change in Status.
- b) *Gain of Coverage Eligibility under Plan of Dependent's Employer.* A Participant's Election to cease or decrease coverage corresponds with the Change in Status only if coverage for the affected individual becomes effective under a qualified benefit plan of a Dependent's employer that provides Similar Coverage.
- c) *Special Consistency Rule for Dependent Care FSA Benefits.* A Participant may change his or her Dependent Care FSA Election if the requested change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code §129.

### Section 7.4.3 Special Change in Status Election for the Plan Years beginning in 2014 and Thereafter

For the Plan Years beginning in 2014 and thereafter, a Participant may make the following Salary Reduction Elections to correspond with IRS Notice 2014-55, Additional Permitted Election Changes for Health Coverage under §125 Cafeteria Plans, issued September 18, 2014. IRS Notice 2014-55 allows a Participant who made a Salary Reduction Election through this Plan to pay for Pre-Tax Premiums for medical benefits provided under the State of Colorado Health Insurance Plan(s), for the Plan Years beginning in 2014 and thereafter, to prospectively revoke an Election with regard to medical benefits provided under the State of Colorado Health Insurance Plan(s) that is not a Health Care FSA and that provides minimum



essential coverage (as defined in §5000A(f)(1)) provided the following conditions are met:

a) **Conditions for Revocation Due to Reduction of Hours of Employment Service**

- (1) The Participant has been in an employment status under which the Participant was reasonably expected to average at least 30 hours of employment service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of employment service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible for medical benefits under the State of Colorado Health Insurance Plan(s); and
- (2) The revocation of the Election of medical benefits coverage under the State of Colorado Health Insurance Plan(s) corresponds to the intended enrollment of the Participant, and any Dependents who cease medical benefits coverage due to the revocation, in another plan that provides minimum essential coverage with the new medical benefits coverage effective no later than the first day of the second month following the month that includes the date the original medical benefits coverage is revoked under the Plan. The revocation of the Election may be made without regard to whether the Participant experienced a Change in Status event as described in Section 7.4.1.

The Plan may rely on the reasonable representation of a Participant who is reasonably expected to have an average of less than 30 hours of employment service per week for future periods that the Participant and Dependents have enrolled or intend to enroll in another plan that provides minimum essential coverage for new medical benefits coverage that is effective no later than the first day of the second month following the month that includes the date the original medical benefits coverage is revoked under the Plan.

b) **Conditions for Revocation Due to Enrollment in a Qualified Health Plan through a Public Marketplace Under ACA**

- (1) The Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a public marketplace under ACA pursuant to guidance issued by the Federal Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a public marketplace under ACA during the public marketplace's annual open enrollment period; and
- (2) The revocation of the Election of medical benefits coverage under the State of Colorado Health Insurance Plan(s) corresponds to the intended enrollment of the Participant and Dependents, who cease medical benefits coverage due to the revocation, in a Qualified Health Plan through a public marketplace under ACA for new medical benefits coverage that is effective beginning no later than the day immediately following the last day of the original medical benefits coverage that is revoked under the Plan. The revocation of the Election may be made without regard to whether the Participant experienced a Change in Status event as described in Section 7.4.1.

The Plan may rely on the reasonable representation of a Participant who has an



enrollment opportunity for a Qualified Health Plan through a public marketplace under ACA that the Participant and Dependents have enrolled or intend to enroll in a Qualified Health Plan for new medical benefits coverage that is effective beginning no later than the day immediately following the last day of the original medical benefits coverage that is revoked under the Plan.

## **Section 7.5 Exceptions to the Irrevocability Rules – Other**

With regard to Pre-Tax Premiums, and coverage under a Health Insurance Plan(s), a Participant may revoke a prior Election and make a new prospective Election if the requested change is on account of and consistent with an event described in this Section 7.5. No change in Election under the Health Care FSA is permitted for the events described in Sections 7.5.4, 7.5.5, 7.5.6, and 7.5.9. An Election change for the Dependent Care FSA is permitted only upon the occurrence of events described in Section 7.5.7. A Participant may elect to change coverage options on the occurrence of one of the events described in this Section 7.4.2, but only to the extent permitted under IRS guidance.

The Plan Administrator reserves the right to determine, at its discretion, based upon IRS guidance, whether a change of Election is on account of and consistent with the Exceptions to Irrevocability Rules described in this Section 7.5.

### **Section 7.5.1 Special Enrollment Rights under HIPAA (health coverage only)**

With respect to Pre-Tax Premiums, if a Participant or his or her Dependent is entitled to Special Enrollment Rights under a group health plan as required by HIPAA in accordance with Code §9801(f), the Participant may revoke a prior Election and make a new Election that corresponds with the Special Enrollment Rights.

The following events give rise to Special Enrollment Rights:

- a) an Employee acquires a Dependent through marriage, birth, adoption, or placement for adoption; or
- b) when the Employee or Dependent has previously declined coverage under a Health Insurance Plan(s) because of coverage under another group health plan (or under other health insurance) and employer contributions toward that coverage cease; or
- c) the Employee or Dependent loses coverage in one of the following specific circumstances:
  - i. if the coverage is not COBRA coverage, the Employee or the Dependent becomes ineligible for coverage, or
  - ii. if the coverage is COBRA coverage, that coverage is exhausted.
  - iii. if an Employee or Dependent loses coverage under Medicaid or a state child health program (SCHIP) due to a loss of eligibility,
  - iv. if an Employee or Dependent becomes eligible for premium assistance under Medicaid or SCHIP,
  - v. if an Employee or Dependent loses eligibility in individual market coverage (including Public Marketplace coverage), if the loss of eligibility is for reasons other than failure to timely pay premiums or termination for cause

An Election to add previously Eligible Dependents as a result of the acquisition of a new Dependent shall be consistent with the Special Enrollment Right, in accordance with federal cafeteria plan Regulations.



### **Section 7.5.2 Entry of a Qualified Medical Child Support Order**

If a QMCSO that satisfies the requirements of §609(a) of the Employee Retirement Income Security Act (ERISA), resulting from a divorce, legal separation, annulment, or change in legal custody requires the Employee's Dependent child to be covered under a group Health Insurance Plan(s), the Participant may make a prospective change in his or her Election so long as it corresponds with the coverage to be provided to the child pursuant to the terms of the QMCSO.

A Participant may make an Election change to cancel coverage for a Dependent child if a QMCSO requires the Spouse, former Spouse, or other individual to provide coverage for the child.

### **Section 7.5.3 Entitlement to Medicare or Medicaid**

A Participant may revoke an Election for Pre-Tax Premiums and/or coverage under a Health Insurance Plan(s) if the Employee, or Dependent who is enrolled in a Health Insurance Plan(s), becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under §1928 of the Social Security Act providing for pediatric vaccines). Coverage changes permitted under this Section 7.5.3 shall result in corresponding modifications of an Election for Pre-Tax Premiums on account of and consistent with the change in coverage.

### **Section 7.5.4 Significant Cost Changes Affecting the Health Insurance Plan**

If the cost of an option offered under the Health Insurance Plan(s) significantly decreases during a Period of Coverage, the Plan Administrator may (i) permit Participants who are enrolled in any other option to prospectively change to the decreased cost plan, and (ii) permit Employees who are not enrolled to elect the decreased cost plan.

If the cost of any option offered under the Health Insurance Plan(s) significantly increases during a Period of Coverage, the Plan Administrator may permit the affected Participants to elect coverage under another option that provides Similar Coverage. If no Similar Coverage is offered, the affected Participants may drop coverage.

Coverage changes permitted under this Section 7.5.4 shall result in corresponding modifications of an Election for Pre-Tax Premiums on account of and consistent with the change in coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether an increase or decrease in cost is significant in accordance with prevailing IRS guidance.

### **Section 7.5.5 Insignificant Cost Changes Affecting the Health Insurance Plan**

In the event of an insignificant increase or decrease in the cost of coverage under the Health Insurance Plan(s), the affected Participant's elective Pre-Tax Premiums shall be automatically increased or decreased on a prospective basis without any affirmative action on the Participant's part.

The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether an increase or decrease is insignificant based on all the surrounding



facts and circumstances, including but not limited to the dollar amount or percentage of the cost change.

#### **Section 7.5.6 Significant Coverage Changes Affecting the Health Insurance Plan**

If coverage under the Health Insurance Plan(s) is significantly curtailed or if the Plan withdraws a Health Insurance Plan(s) benefit option during a Period of Coverage, affected Participants may elect another option offered by the Employer that provides Similar Coverage. If no Similar Coverage is offered, Participants may drop coverage.

If coverage under the Health Insurance Plan(s) is significantly improved or if the Plan adds a new benefit option during a Period of Coverage, the Plan Administrator may permit (i) Participants who are enrolled in an option other than the newly added or significantly improved option to change their Election on a prospective basis to elect the newly-added or significantly improved option, and (ii) Employees who are not enrolled to elect the newly-added or significantly improved option on a prospective basis.

Coverage changes permitted under this Section 7.5.6 shall result in corresponding modifications of an Election for Pre-Tax Premiums on account of and consistent with the change in coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a curtailment or improvement is significant in accordance with prevailing IRS guidance.

#### **Section 7.5.7 Changes Affecting Dependent Care**

A Participant may prospectively change his or her Dependent Care FSA Election on account of and consistent with the following.

- a) *Significant cost change.* If during a Period of Coverage, the cost of Dependent Care changes significantly, the Participant may make a corresponding, prospective Election change to his Dependent Care FSA, but only if the Dependent Care provider is not a relative of the Employee as described in Code §152(a)(1) through (8).
- b) *Change 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 qualified dependent care plan, in accordance with applicable IRS regulations.

#### **Section 7.5.8 Loss of Coverage Under Other Group Health Coverage.**

An Employee may elect to enroll or increase his or her Pre-Tax Premium for the Health Insurance Plan(s) if such Employee or his or her Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including but not limited to:

- a) a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act;
- b) a medical care program of an Indian Tribal government (as defined in Code §7701 (a)(40)), the Indian Health Service, or tribal organization;
- c) a state health benefits risk pool; or



- d) a foreign government group health plan.

### **Section 7.5.9 Change in Coverage Under Another Employer Plan**

A Participant may make a prospective Election change to his or her Pre-Tax Premium that is on account of and consistent with a change made under another qualified plan in accordance with applicable IRS regulations.

**Example:** Open Enrollment for Participant's Spouse's employer-sponsored, qualified group health insurance plan is held in October. The Spouse enrolls the entire family for the plan year commencing January 1. Participant may make a corresponding Election to drop family medical coverage effective January 1. However, a request to reduce the Participant's Health Care FSA is not consistent with the change of medical coverage and would not be permitted.

The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer's plan, in accordance with prevailing IRS guidance.

### **Section 7.6 Effect of Change of Coverage During a Benefit Period**

If during a Period of Coverage, a Participant makes a new Election as provided in this Article VII, Benefits for expenses incurred on or after the first day of the Period of Coverage, but prior to the effective date of the new Election, shall be determined in accordance with the Election in effect prior to the change. Benefits for expenses incurred on or after the effective date of the Election change shall be determined in accordance with the new Election, reduced by the amount of Eligible Expenses incurred and reimbursable prior to the effective date of the change.

**Example 1:** During Open Enrollment, an Employee elects to contribute \$1,200 to a Health Care FSA. In September, the Employee incurs unanticipated medical expenses when the Employee's baby is born prematurely. The Employee may increase his or her annual Election effective October 1. However, reimbursement for Qualifying Medical Expenses incurred prior to October 1 will be limited to \$1,200.

**Example 2:** During Open Enrollment, an Employee elects to contribute \$2,500 to the Health Care FSA for the plan year because the Employee's Spouse is gravely ill. The Spouse dies on September 15 after incurring \$1,500 of Qualifying Medical Expenses. The Employee may reduce annual Election effective October 1, but the new annual election cannot be less than \$1,500.

## **Article VIII. COBRA Compliance**

### **Section 8.1 Continuation of Coverage**

In the event an Employee or Eligible Dependent who is participating in the Plan experiences a Qualifying Event under COBRA, coverage under the Health Insurance Plan(s) may be continued as required by COBRA, on an after-tax basis outside of this Plan.

Coverage under the Health Care FSA may be continued until the end of the Plan Year in which a Qualifying Event occurs if on the date of the Qualifying Event, the Health Care FSA has a positive balance (year-to-date contributions exceed year-to-date reimbursements).



The Dependent Care FSA is not subject to COBRA and continuation of the Dependent Care FSA is not permitted.

## **Section 8.2 Payment**

Each Qualified Beneficiary who elects continuation of coverage under this Article VIII shall be required to pay to the Plan Administrator the monthly Premium for coverage under the Health Insurance Plan(s) and Salary Reduction for Health Care FSA on an after-tax basis. In addition to the Premium, each Qualified Beneficiary is required to pay an additional two-percent (2%) COBRA administrative fee during the period of continuation.

## **Article IX HIPAA Compliance**

### **Section 9.1 HIPAA Compliance**

It is intended that the Health Care FSA portion of this Plan meet all applicable requirements of HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), and of all regulations issued there under. The Health Care FSA is a group health plan and is intended to be administered in compliance with HIPAA.

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

The Plan will use Protected Health Information (PHI) in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to health care, health care operations, and other disclosures permitted under §512 of the HIPAA Privacy Rule.

Except as permitted by HIPAA, the Plan will only use or disclose PHI for marketing purposes or sell (exchange) PHI for remuneration (payment) with an individual's written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a Health Care FSA benefit claim, appeal or for other reasons related to the administration of the Health Care FSA.

### **Section 9.2 Privacy Rule Compliance**

The Plan Administrator has adopted policies and procedures to protect the privacy and provide for the security of PHI as such may be disclosed to the Plan Administrator, its representatives and business associates in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable rules as amended.

The Plan Administrator shall:

Not use or further disclose PHI other than as permitted or required by the Plan documents or pursuant to HIPAA;

- a) Not use or disclose PHI obtained in its capacity as a covered entity for employment-related actions and decisions, or without Participant authorization in connection with any other benefit or employee benefit plan of the State;



- b) Report to the Plan's privacy officer any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for under HIPAA;
- c) Make PHI available to an individual based on HIPAA's access requirements in accordance with 45 C.F.R. § 164.524;
- d) Make PHI available for amendment and incorporate any PHI amendments based on HIPAA's amendment requirements in accordance with 45 C.F.R. § 164.526;
- e) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- f) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of
- g) Health and Human Services to determine the Plan's compliance with HIPAA;
- h) If feasible, return or destroy all PHI received from the Plan that Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the specified disclosure purpose. If return or destruction is not feasible, the Plan Administrator will limit further uses and disclosures to those purposes that make the return or destruction infeasible;
- i) If a breach of a plan participant's unsecured protected health information (PHI) occurs, the Plan will notify the individual.

A complete description of an individual's rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which is distributed to individuals upon enrollment in the Health Care FSA, and is also available from the Plan Administrator. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

**Adequate Separation:** In order to ensure that adequate separation between the Health Care FSA group health plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or Business Associates may be given access to use and disclose PHI: The Plan Administrator and the independent claims administrator who is administering the Health Care FSA program. These persons may only have access to and use and disclose PHI for Plan administration functions. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance with HIPAA. Issues of noncompliance (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (available by contacting the Plan Administrator defined in this Plan).

Effective April 21, 2005 in compliance with HIPAA Security regulations, the Plan Sponsor will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
2. Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

## Article X. Administration

### **Section 10.1 Powers of the Plan Administrator**

The State of Colorado, Department of Personnel & Administration, Division of Human Resources (the "Plan Administrator") shall administer the Plan and shall exercise the powers and discretion



conferred on it.

The Plan Administrator may delegate to any agent, third-party administrator, attorney, accountant, or other person selected by it, any power or duty vested in, imposed upon, or granted to it by the Plan.

Notwithstanding the foregoing, the Plan Administrator shall have the following discretionary authority:

- a) The sole and absolute discretion 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, in accordance with the applicable statutes, rules and directives;
- b) To prescribe procedures to be followed and the forms to be used by Employees and Participants to make Elections pursuant to the Plan;
- c) To prepare and distribute information explaining the Plan and the benefits under the Plan in such manner as the Plan Administrator determines to be appropriate;
- d) To request and receive from all Participants such information as the Plan Administrator determines to be necessary for the proper administration of this Plan;
- e) To furnish each Participant with such notices and reports as the Plan Administrator determines from time to time to be necessary and proper;
- f) To receive, review and keep on file such reports and information regarding the benefits covered by this Plan as the Plan 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 the Plan Administrator determines to be necessary or advisable, including legal counsel and benefit consultants;
- h) To secure independent medical or other advice and require such evidence as the Plan Administrator deems necessary to decide any claim or appeal; and
- i) 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.

## **Section 10.2 Account Balance**

A Participant's eligible Health Care FSA and Dependent Care FSA shall be held open until October 15 following the end of the prior Plan Year. During that time, proof of eligible health care and dependent care expenses incurred during the Plan Year may be submitted to the Plan Administrator or its agent for payment from the appropriate account. A Participant with any dollar balances in his or her Dependent Care FSA as of October 16 following the Plan Year shall forfeit all monies remaining in the account(s).

A Participant with any dollar balances in his or her Health Care FSA as of October 16 following the Plan Year, which are in excess of the carryover amount from the prior year, shall forfeit all monies remaining in the account(s) that exceed the permitted carryover amount explained in Section 4.6. This rule shall also apply to forfeitures under the last paragraph of Section 4.6, regarding certain carryovers that remain unused for one full Plan Year.

Forfeited balances shall be used by the Employer first to offset any losses experienced by the



Employer during the Plan Year as a result of making reimbursement to any Participant in excess of the Contributions paid by such Participant; second to reduce the Employer's reasonable administrative expenses for administering the Plan; and third to reduce Premiums or increase coverage to Participants in the following Plan Year in the manner the Employer deems appropriate.

### **Section 10.3 Errors**

Participants are responsible for reviewing their elections and Confirmation Notices and for reporting errors to the Plan Administrator within the period for correcting such errors as may be established by the Plan Administrator and before the commencement of the Plan Year.

Discrepancies between the submitted electronic election and the electronic payroll record must be reported by the Participant no later than thirty-one (31) calendar days following the first payroll deduction of the Plan Year. The payroll record shall be corrected to conform to the submitted election.

### **Section 10.4 Overpayments and Fraud**

If for any reason, any Benefit under the Plan is erroneously paid to a Participant, Dependent or other person, the Participant shall be responsible for refunding the overpayment to the Plan by lump sum payment, reduction, or offset of the amount of future benefits otherwise payable, or any other method as determined by the Plan Administrator in its sole discretion. Any person claiming benefits under the Plan shall furnish the Plan Administrator with such information and documentation as may be necessary to verify eligibility for benefit under the Plan.

If a person is found to have falsified any document in support of a claim or coverage under the Plan, the Plan Administrator may without the consent of any person, terminate coverage and refuse to honor any claim under the Plan for the Participant and Dependent related to the person submitting the falsified information, as well as any other sanctions allowed by *Personnel Board Rules and Personnel Director's Administrative Procedures*.

### **Section 10.5 Funding**

All of the amounts payable under this Plan shall be paid from the general assets of the State. Nothing in this Plan will be construed to require the State or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participants, 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 under this Plan are paid.

## **Article XI. General Provisions**

### **Section 11.1 Illegality of Particular Provision**

The illegality of any particular provision of this Plan shall not affect the other provisions, but the Plan shall be construed in all respects as if such invalid provision were omitted.

### **Section 11.2 Applicable Laws**

The Plan shall be governed by and construed according to the laws of the State of Colorado to the extent not superseded by the Code, or any other federal law.



### **Section 11.3 Plan Provisions Controlling**

In the event that the terms or provisions of any summary or description of the 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.

### **Section 11.4 Compliance**

It is intended that this Plan meet all applicable requirements of the Code and all Regulations issued there under. 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, the provisions of the Code shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

All provisions of this plan shall be interpreted and applied in a uniform, nondiscriminatory manner.

### **Section 11.5 Effect of Compliance**

The Plan Administrator reserves the right to reverse or modify an Employee's Salary Reductions as necessary in order to comply with all nondiscrimination requirements of the Code and other applicable legislation or Regulations without the consent of the Employee. Modification of Salary Reduction amounts result in the Employee receiving the converted amount as taxable cash pro-rata throughout the year. Employees will be notified within sixty (60) days of the time any necessary modification of their Salary Reduction occurs.

### **Section 11.6 Effect on Income Tax Return**

A Participant is not eligible to claim a deduction under §213 of the Code or a credit under §21 of the Code for any monies allocated for the Pre-Tax Premiums and/or the Health Care FSA and Dependent Care FSA under Articles III, IV and V for that specific Plan Year. While the Plan is intended to qualify as a cafeteria plan under §125 and §129 of the Code, the State of Colorado and the Plan Administrator make no guaranty that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes.

### **Section 11.7 No Deferred Compensation**

In accordance with federal cafeteria plan Regulations, Salary Reductions in a specified Plan Year may not be used for any Period of Coverage other than the same Plan Year. In no event shall Benefits under the Plan be provided in the form of deferred compensation.

### **Section 11.8 Non-Alienation of Benefits**

Benefits provided under the Plan are not subject to attachment, assignment, transfer, lien, garnishment, levy of execution, bankruptcy proceedings, or other legal process at any time, either directly or by operation of law, and any attempt to cause the same is null and void.



## Section 11.9 Employment Rights

The adoption and maintenance of the Plan and participation in the Plan, and the provisions contained herein, shall not be construed to:

- a. Create a contract of employment between the State of Colorado and an Employee; or
- b. Give an Employee the right to be retained in the employ of the State of Colorado; or
- c. Interfere with or diminish the right of the State of Colorado to discharge an Employee at any time; or
- d. Give the State of Colorado the right to require an Employee to remain in its employ or interfere with the Employee's right to terminate his or her employment at any time.

## Section 11.10 Number and Gender

Unless otherwise indicated by the context, terms used in the singular also include the plural and vice versa; and terms in the masculine also include the feminine and vice versa.

## Section 11.11 Headings

The headings of the various Articles, Sections and 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.

## Article XII. Appeals

### Section 12.1 Appeal From Denial of Claims

Claims for reimbursement of Qualifying Medical Expenses under the Health Care FSA and Qualifying Dependent Care Expenses under the Dependent Care FSA must be filed along with proof to substantiate the claim with the TPA pursuant to Sections 4.5 and 5.5. If any claim for reimbursement of expense under the Plan is wholly or partially denied by the TPA, the claimant shall be given notice in writing of such denial within forty-five (45) days after receipt of the claim, setting forth the following information:

Identify the claim involved (e.g. date of service, health care provider, and claim amount if applicable);

The specific reason or reasons for such denial;

- a) Reference to pertinent Plan provisions on which the denial is based;
- b) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of such material or information as necessary;
- c) An explanation that full and fair review of the decision denying the claim may be requested by the claimant or his authorized representative by filing with the Plan Administrator within sixty (60) days after such notice has been received, a written request for such review; and
- d) If such request is so filed, the claimant or his authorized representative may review pertinent documents and submit issues and comments in writing within the same sixty (60) day period specified in 12.1(d) above.
- e) If a claimant does not understand English and has questions about a claim denial, they will be directed to contact the Plan's Claims Administrator for assistance.
  - i. SPANISH (Español): Para obtener asistencia en Español, llame al



- [1.800.659.3035].
- ii. TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa [1.800.659.3035].
- iii. CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 [1.800.659.3035].
- iv. NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' [1.800.659.3035].

The decision of the TPA shall be made promptly, and not later than forty- five (45) days after the receipt of the request for review, unless special circumstances require an extension of time for processing, in which case the claimant shall be so notified and a decision shall be rendered as soon as possible, but not later than ninety (90) days after receipt of the request for review. The claimant shall be given a copy of the decision promptly. The decision shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, and specific references to the pertinent Plan provisions on which the decision is based.

### **Section 12.2 Appeal from Denial of Enrollment, Election, or Change Request**

Requests for enrollment and change requests must be submitted in accordance with the applicable administrative procedures and directives. If any application for enrollment, election, or change request is wholly or partially denied, the applicant or Participant may file with the Plan Administrator within thirty-one (31) days after the denial, a written request for a full and fair review of the decision.

### **Section 12.3 Appeal from Decision of the Plan Administrator**

In the event a Participant's appeal is denied by the Plan Administrator in Sections 12.1(d) and 12.2 above the Participant may appeal to the State Personnel Director in writing within thirty- one (31) days of such denial as set forth in Chapters 8 and 11 of the Director's Administrative Procedures. The Director will issue a final written decision within ninety (90 days) from receipt of the appeal. The Director's decision is final and binding upon all parties including the Employer, the Participant and Dependents, their respective families, dependents, successors, assigns, executors, administrators and legal representatives.

## **Article XIII. Amendment and Termination**

### **Section 13.1. Amendment and Termination of the Plan**

The State of Colorado expects the Plan to be permanent, but since future conditions cannot be anticipated or foreseen, the State must necessarily and does hereby reserve the right to amend, modify, or terminate the Plan, in whole or in part, at any time. The Plan Administrator may make any modifications or amendments to the Plan that are necessary or appropriate to maintain the Plan in accordance with the requirements of the applicable sections of the Code and Regulations. The Plan shall not be used for or diverted to purposes other than for the exclusive benefit of Participants or their Dependents, and no amendment shall divest any person of his interest therein, except as may be required by the IRS or other governmental authority, or give any person any assignable or exchangeable interest, or any right or thing of exchangeable value in advance of the time distribution is to be made to such person.

In WITNESS WHEREOF, the State of Colorado has caused this instrument to be executed,



effective as of July 1, 2018.

STATE OF COLORADO  
John Hickenlooper, Governor

By: Marie Davis  
Marie Davis  
Director, Employee Benefits

Date: July 1, 2018



