

The State of Colorado Salary Reduction Plan

For

The State of Colorado Employees and Officials

Adopted June 1, 1987

Amended and Restated March 18, 2011

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 amended and restated effective June 1, 2004, and was subsequently amended effective June 1, 2005 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, 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 Plans.

“**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.

“**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.

“**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 the Colorado Revised Statutes §24-50-603(5), “Definitions”, as amended and includes an Employee’s Spouse, Same-Gender Domestic Partner, and children. *Note: Benefits are not provided under this Plan for Dependents who are not also Tax Dependents as defined herein.*

“**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.

“Effective Date” means August 1, 1987, the original effective date of the Plan; the restated effective date is March 18, 2011.

“Election” means and refers to the specific benefit options chosen by a Participant 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 and any documentation that may be required by the Plan Administrator to verify eligibility.

“Employee” has the meaning given to the term in the Colorado Revised Statutes 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.

“Employer” means and refers to the State of Colorado. The Colorado Department of Personnel & Administration located at 633 17th Street, Suite 1600, Denver, Colorado 80203, has statutory authority for providing benefits to Employees as provided in Colorado Revised Statutes 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.

“Health Insurance Plan(s)” means the plan or plans, maintained by the Employer for its Employees and for the Employees’ Dependents eligible under the terms of such plans, providing medical and dental benefits through a group insurance policy or policies or self-funded arrangement.

“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, and associated Regulations (the “HIPAA Regulations”).

“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 Plans and FSA plans. This period shall be determined on an annual basis by the Plan Administrator, but shall commence no earlier than April and end not 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 Benefits, Health Care FSA Benefits, or Dependent Care FSA Benefits.

“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 next 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 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 Flexible Spending Account, 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, 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 or 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.

“Regulations” means the applicable regulations issued under the Code by the Internal Revenue Service, 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, 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 which trigger Special Enrollment Rights.

“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.

“Tax-Dependent” means a Dependent for whom the Employee may claim an exemption for federal tax purposes in accordance with §152. For purposes of the Health Insurance Plan and Health Care FSA, the term also includes any Child of the Employee as defined in §152 (f)(1) who as of the end of the calendar year has not attained age 27, even if the child does not qualify as an exemption.

“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 group Health Insurance Plans. 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.

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 on the Election Form 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 Flexible Spending Account 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).

An Employee may voluntarily elect to participate by designating the amount to be contributed to a Health Care Flexible Spending Account on the Election Form 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 Flexible Spending Account 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.

Section 4.2 Funding of Health Care Flexible Spending Account

The State of Colorado shall contribute to each Participant's Health Care Flexible Spending Account the Pre-Tax Contribution designated by the Participant on the Election Form 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 Flexible Spending Account for any Participant in any Period of Coverage shall be established by the Plan Administrator. The maximum contribution amount for the Health Care FSA has been and will be:

- Plan Years August 1, 1987 through December 31, 2004 \$6,000
- Plan Year January 1, 2005 through June 30, 2005 \$3,000
- Plan Year July 1, 2005 through June 30, 2012 \$6,000
- Plan Years commencing July 1, 2012 and thereafter \$2,500

The minimum contribution amount is \$120.

Under the ACA, the maximum contribution to a Health Care Flexible Spending Account that may be excluded from income for any Participant in any calendar year beginning in 2013 is \$2500. 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.

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 Third-party Administrator 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 Third-party Administrator. A claim reimbursement must be filed by the deadline in Section 10.2.

Section 4.6 Forfeiture of Account Balance, “Use it or Lose it” Rule.

In the event the amount reimbursed to an 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. 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 or increase coverage to Participants in the following Plan Year in the manner the Employer deems appropriate.

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 Flexible Spending 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 include amounts paid for the purchase of medical services, prescription drugs, insulin, and medical supplies but do not include over-the-counter drugs or medicines purchased without 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 Flexible Spending Account. 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.

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 Internal Revenue Service 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.

Section 4.10 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 Health Care Flexible Spending Account.

Article V. Dependent Care Flexible Spending Account

Section 5.1 Benefits

The Dependent Care Flexible Spending Account 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 Flexible Spending Account on the Election Form 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 Flexible Spending Account 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 Flexible Spending Account

The Employer shall contribute to each Participant's Dependent Care Flexible Spending Account the Pre-Tax Contribution designated by the Participant on the Election Form 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 Flexible Spending Account that may be excluded from income for any Participant in any calendar year is the lesser of:

- a) In the case of an Employee who is not married at the close of the calendar year, the Employee's earned income for that year; or
- b) In the case of an Employee who is married at the close of the calendar year, the lesser of the Employee's earned income or the earned income of the Employee's spouse for that year; or
- c) \$5,000 (\$2,500 in the case of an Employee who is married at the close of the calendar year and who files a separate Federal income tax return).

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 Flexible Spending Account 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 Flexible Spending Account for any Participant in any Plan Year is \$120.

Section 5.4 Dependent Care Flexible Spending Account 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 Flexible Spending Account 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 Flexible Spending Account 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 Flexible Spending Account, 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 Third-party Administrator 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 Flexible Spending Account 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 Flexible Spending Account 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 Internal Revenue Service 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 Flexible Spending Account.

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.

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 submit a timely Election Form 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, Employees may:

- a) Elect to fund Health Insurance Plan 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 Premiums on an after-tax basis by prospectively designating the after-tax option; and/or
- c) Elect to participate in either or both the 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 either the Health Insurance Plans or 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 in the case of health insurance benefits for which automatic enrollment is required under the ACA, 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 following Plan Year provided a properly completed Election Form is submitted 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 Employees may elect Health Insurance Coverage, Pre-Tax Premiums and/or establish Health Care FSA and Dependent Care FSA accounts 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 for which automatic enrollment is required under the ACA, will be deemed to have elected the default plan option designated by the Plan Administrator with premiums paid with after-tax contributions.

Elections made by new 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 (30) 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 the Election Form is submitted, except that newborn and adopted children shall be covered as of the date of birth, adoption or placement for adoption provided that an Election Form 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 Health Care FSA or Dependent Care FSA accounts.

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 provisions or Premiums, the Plan Administrator, may by written directive, permit passive enrollment in the Health Insurance Plans, 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 FSA and Dependent Care FSA accounts *cannot* be automatically renewed. A new Election is required each Plan Year for participation in the Health FSA and Dependent Care FSA accounts.

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 Family and Medical Leave Act

If a Participant takes unpaid leave under the Family and Medical Leave Act (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 Family Medical 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 Flexible Spending Account, a Participant whose coverage ceased shall be reinstated in the Health Care Flexible Spending Accounts 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 the Uniformed Services Employment and Reemployment Rights Act 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 Flexible Spending Account, a Participant whose coverage ceased shall be reinstated in the Health Care Flexible Spending Accounts 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 Family and Medical 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 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 Flexible Spending Account 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 (30) 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 more than thirty (30) 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 or Health 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 Plans, Pre-Tax Premiums, and the Dependent Care and Health Care Flexible Spending Accounts 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 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 Election Form 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. 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 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 and timely Election Form.

Section 7.4 Exceptions to the Irrevocability Rules - Change in Status

With regard to Pre-Tax Premiums, coverage under a Health Insurance Plan, Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, 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) A change in a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation, and annulment.
- b) Events that change a Participant's number of Tax Dependents, including birth, death, adoption, and placement for adoption.
- c) 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.
- d) Events that cause a Participant's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age.
 - e) Change in the Employee's place of residence.

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, 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 7.5 Exceptions to the Irrevocability Rules – Other

With regard to Pre-Tax Premiums, and coverage under a Health Insurance Plan, 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 Flexible Spending Account is permitted for the events described in this Section 7.5 and an Election change for the Dependent Care Flexible Spending Account is permitted only upon the occurrence of events described in 7.5.7.

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 because of coverage under another group health plan (or under other health insurance) and employer contributions toward that coverage cease or 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.

(c) if an Employee or Dependent loses coverage under Medicaid or a state child health program (SCHIP) due to a loss of eligibility, or

(d) if an Employee or Dependent becomes eligible for premium assistance under Medicaid or SCHIP.

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.

HIPAA relates solely to the addition of medical benefits coverage under a Health Insurance Plan on the occurrence of a special enrollment event. It does not permit the cancellation of coverage under any circumstances and does not apply to Dental, Health FSA, or Dependent FSA benefits.

Section 7.5.2 Entry of a Qualified Medical Child Support Order

If a Qualified Medical Child Support Order (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, 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 if the Employee, or Dependent who is enrolled in a Health Insurance Plan, 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 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 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, 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 is significantly curtailed or if the Plan withdraws a Health Insurance Plan 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 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 Flexible Spending Account 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 Flexible Spending Account, 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 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 \$1200 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 \$1200.

Example 2: During Open Enrollment, an Employee elects to contribute \$6000 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 \$4000 of Qualifying Medical Expenses. The Employee may reduce annual Election effective October 1, but the new annual election cannot be less than \$4000.

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 may be continued as required by COBRA, on an after-tax basis outside of this Plan.

Coverage under the Health Care Flexible Spending Account 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 Flexible Spending Account has a positive balance (year-to-date contributions exceed year-to-date reimbursements).

The Dependent Care Flexible Spending Account is not subject to COBRA and continuation is not permitted.

Section 8.2 Payment

Each Qualified Beneficiary who elects continuation of coverage under this Article X shall be required to pay to the Plan Administrator the monthly Premium for coverage under the Health Insurance Plan and Salary Reduction for Health 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 this Plan meet all applicable requirements of the Health Insurance Portability and Accountability Act (HIPAA) and of all regulations issued there under. The Plan is a group health plan and a covered entity under 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.

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:

- a) Not use or further disclose PHI other than as permitted or required by the Plan documents or pursuant to HIPAA;
- b) 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;
- c) 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;
- d) Make PHI available to an individual based on HIPAA’s access requirements in accordance with 45 C.F.R. § 164.524;
- e) 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;
- f) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F. R. §164.528;
- g) 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 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.

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 and Dependent Care Flexible Spending Accounts shall be held open until October 15 following the end of the 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 Health Care and Dependent Care Flexible Spending Accounts as of October 16 following the Plan Year shall forfeit all monies remaining in the account(s).

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; and second to reduce the Employer's reasonable administrative expenses for administering the Plan.

Section 10.3 Errors

Participants are responsible for reviewing their Election Forms 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 Election Form and the electronic payroll record must be reported by the Participant no later than ten (10) calendar days following the first payroll

deduction of the Plan Year. The payroll record shall be corrected to conform to the submitted Election Form.

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*.

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.

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 Internal Revenue Code or a credit under §44A of the Internal Revenue Code for any monies allocated for the Pre-Tax Premiums and/or the Health Care and Dependent Care Flexible Spending Accounts 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 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 Flexible Spending Account and Qualifying Dependent Care Expenses must be filed along with proof to substantiate the claim with the Third-party Administrator 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 Third-party Administrator, 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:

- a) The specific reason or reasons for such denial;
- b) Reference to pertinent Plan provisions on which the denial is based;
- c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of such material or information as necessary;
- d) 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
- e) 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.

The decision of the Third-party Administrator 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 Internal Revenue Service 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 March 18, 2011.

STATE OF COLORADO
John Hickenlooper, Governor

By: 
Guy Mellor, Director
Division of Human Resources