

The University of Colorado Flexible Benefits Plan

For

The University of Colorado Employees and its Participating Affiliates

Amended and Restated July 1, 2021

Article I. Scope

Section 1.1 Title

This document shall be entitled, be known as, and be referred to as the “Flexible Benefits Plan” (the “Plan”) for the University of Colorado Employees and its Participating Affiliates. The Plan is established by The Regents of the University of Colorado, a body corporate and a state institution of higher education of the State of Colorado (the “University of Colorado”). The Plan includes all provisions contained hereunder and is administered by the University of Colorado System Administration located at 1800 Grant Street, Suite 620, Denver, CO 80203, hereafter referred to as the “Plan Administrator.”

Section 1.2 Scope

The University of Colorado established the predecessor to this Plan, the University of Colorado - Faculty, Unclassified Administrators, and Classified Staff Flexible Spending Account Plan, originally effective July 1, 1987, restated effective January 1, 1990, restated effective January 1, 1999, amended and restated January 1, 2006, amended and restated July 1, 2010, amended and restated July 1, 2014, amended and restated July 1, 2015, amended and restated July 1, 2020, and hereby amended and restated July 1, 2021, except as otherwise provided herein, to provide Employees of the Employer the tax savings opportunities permissible under Section 125 of the Internal Revenue Code of 1986, as amended (the “Code”) for:

- (a) Employee contributions required under the Employer’s Health Insurance Plan(s); herein referred to as the “Premium Only Plan”;
- (b) Contributions to an account for the reimbursement of certain Qualifying Medical Expenses, herein referred to as the “Health Care FSA”;
- (c) Contributions to an account for the reimbursement of certain Qualifying Dependent Care Expenses, herein referred to as the “Dependent Care FSA”;
- (d) Health Savings Account, herein referred to as the “HSA”; or
- (e) Any combination of the foregoing, except that (d) may not be combined with (b), as shall be provided pursuant to the Employer’s welfare benefit plans subject to the rules and regulations set forth herein.

This document contains definitions and general administrative provisions that govern the Plan. The Plan is intended to qualify as a “cafeteria plan” within the meaning of Code Section 125. The Health Care FSA is intended to qualify under Code Sections 105 and 106, and is considered to be a separate plan to the extent required by law. The Dependent Care FSA is intended to qualify under Code Section 129 and is considered to be a separate plan to the extent required by law. The

HSA funding feature described in Article VI is not intended to establish an ERISA plan or to otherwise be a part of an ERISA benefit plan. This Plan is intended to be a governmental plan not subject to Title I of ERISA.

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.

“Affiliate” means University License Equity Holdings, Inc., University of Colorado Hospital Authority and University Physicians, Inc., d/b/a University of Colorado Medicine (“UPI”).

“Benefit(s)” means the Premium Only Plan Benefits, the Health Care FSA Benefits, the Dependent Care FSA Benefits and HSA Benefits offered under the Plan.

“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 7.2 and 7.3 of this Plan. In addition, special provisions apply to the HSA Benefits as described in Article VI.

“Cafeteria Plan” means a written plan that meets the requirements of Code Section 125 and offers participating Employees a choice between cash and certain non-taxable benefits, such as health insurance through 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 8.4.1.

“COBRA” means the provisions requiring continuation of employer-sponsored group health coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and incorporated into Title 22 of the Public Health Service Act, 42 U.S.C. § 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 Enrollment Election(s) for the Plan Year. The term includes notices provided in any format, including electronic or online notification.

“Dependent” means any individual who is a dependent of the Participant as defined in Code Section 152, with the following exceptions:

- (a) for purposes of accident or health coverage (to the extent funded under the Premium Only Plan component, and for purposes of the Health Care FSA component),
 - (1) a dependent is defined as in Code Section 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and
 - (2) any child to whom IRS Rev. Proc. 2008-48 applies (regarding a child of divorced or separated parents who receives more than half of the support for the calendar year from one or both parents and is in the custody of one or both parents for more than half of the calendar year) is treated as a dependent of both parents; and
 - (3) effective on or after March 30, 2010, a dependent includes any child (as defined in Code Section 152(f)(1)) of a Participant who has not attained age 27;

Notwithstanding the foregoing, the Health Care FSA component will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order, even if the child does not meet the definition of “Dependent”; and

- (b) for purposes of the Dependent Care FSA component, a Dependent is a “Qualifying Individual” as defined in Code Section 21(b)(1) with respect to the Participant, and in the case of divorced parents, a Qualifying Individual who is a child shall, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)(1)) and shall not be treated as a Qualifying Individual with respect to the noncustodial parent.

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

“Domestic Partner” means a person who meets the criteria for a domestic partner of an Eligible Employee under the Employer’s policy.

“Effective Date” means the original Plan effective date of July 1, 1987; the amended and restated effective date of this Plan is July 1, 2021.

“Election” means and refers to the specific benefit options chosen by a Participant for a given Plan Year, the level of benefit and the annual Pre-Tax Contribution designated to fund the benefit.

“Election Form” refers to the form(s) or means provided by the Plan Administrator for the purpose of allowing an Eligible Employee to elect, during the annual Open Enrollment Period, upon first becoming an Eligible Employee, or as permitted in Article VII, to participate in this Plan. The Election Form may also be used to change or revoke an Election as provided in Article VIII of this Plan. The term includes forms provided in any format, including electronic or online forms.

“Eligible Dependent” means a Spouse or Dependent as defined herein.

“Eligible Employee” means an Employee eligible to participate in this Plan, as provided in Article VII but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual

classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement, unless the collective bargaining agreement specifies that the employees covered under the agreement must be covered by the Plan; and (d) any self-employed individual.

“Employee” means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll.

“Employer” means and refers to The Regents of the University of Colorado, a body corporate and a state institution of higher education of the State of Colorado (the “University of Colorado”) including the University of Colorado – Boulder Campus, the University of Colorado - Denver and Anschutz Medical Center, the University of Colorado - Colorado Springs, and the University of Colorado System Administration. The term also includes the University of Colorado's Affiliates. However, for purposes of Article XIII, Article XIV and Article XVII, “Employer” means only the University of Colorado in its role as Plan Sponsor. Affiliates who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. An Affiliate may not revise the terms of this Plan, and participation in this Plan by the Affiliate's Eligible Employees shall be on the same terms as the Plan Sponsor's Eligible Employees.

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

“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 VIII of this Plan.

“Family Medical Leave” means a paid or unpaid leave of absence under FMLA.

“FMLA” means the Family and Medical Leave Act of 1993, as amended, and including all Regulations promulgated pursuant thereto.

“Grace Period” means the period that begins immediately following the close of the Plan Year and ends on the day that is two (2) months plus fifteen (15) days following the close of that Plan Year. For the Plan Year commencing July 1, 2019 and ending June 30, 2020 only, the Grace Period is extended to December 31, 2020 as allowed for in IRS Notice 2020-29. For the Plan Year commencing July 1, 2020 and ending June 30, 2021 only, the Grace Period is extended to June 30, 2022, as allowed for in the Consolidated Appropriations Act, 2021, Pub. L. 116-260, 134 Stat. 1182 (December 27, 2020). The provisions of this Plan regarding this extended Grace Period for the Plan Years ending June 30, 2020 and June 30, 2021 shall be administered in accordance with applicable IRS guidance, including IRS Notice 2020-29 and IRS Notice 2021-15 (and any subsequent IRS guidance).

“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 Eligible Employees, their Spouses, and Dependents eligible under the terms of such plans, providing medical, dental and vision benefits through a group insurance policy or policies or self-funded arrangement.

“HIPAA” refers to provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and Regulations promulgated thereunder by the U.S. Department of Health and Human Services (the “HIPAA Regulations”).

“IRS” means the Internal Revenue Service.

“Open Enrollment Period” means the period during which an Eligible Employee may enroll in The University of Colorado Flexible Benefits Plan for the next Plan Year. This period shall be determined on an annual basis by the Employer.

“Participant” means an Eligible Employee of the Employer who elects to participate and is participating in this Plan in accordance with the provisions of Article VII of this Plan. Participants include those who elect one or more of the Premium Only Plan Benefits, Health Care FSA Benefits, Dependent Care FSA Benefits, or HSA Benefits.

“Participating Affiliate(s)” means the University of Colorado and University Physicians, Inc.

“Partner in a Civil Union” means a person who is (a) a partner in a civil union between two individuals pursuant to the Colorado Civil Union Act, C.R.S. § 14-15-101 *et seq.*, as may be amended from time to time and (b) not anyone’s Spouse.

“Period of Coverage” means the period of time during the Plan Year in which required contributions are made. The Period of Coverage shall commence on the Benefit Effective Date and shall remain in effect for an entire Plan Year, or in the case of a new Employee, for the remainder of the Plan Year. Except as provided in Article VII of this Plan, a Participant’s Period of Coverage shall be uninterrupted during the Plan Year.

“Plan” means The University of Colorado Flexible Benefits Plan set forth herein and as amended from time to time.

“Plan Administrator” means the University of Colorado System Administration. For purposes of the Premium Only Plan for medical, dental, and vision benefits and the Health Care Flexible Spending Account, Plan Administrator specifically means CU Health Plan Administration. For purposes of the Dependent Care Flexible Spending Account and the HSA, Plan Administrator specifically means Employee Services.

“Plan Sponsor” means The Regents of the University of Colorado, a body corporate and a state institution of higher education of the State of Colorado (the “University of Colorado”).

“Plan Year” means the six-month period commencing January 1 and ending on June 30, 2005 of that same calendar year. Thereafter, the Plan Year means the twelve-month period commencing each July 1 and ending the following June 30. The initial Plan Year refers to the period from July 1, 1987 to December 31, 1987.

“Premium” means the amount required to be contributed to pay for the cost of Health Insurance Plans.

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

“Premium Only Plan” refers to: (a) the benefits described in Article III of this Plan; and (b) 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. Section 160.103.

“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 Care Expense” means the expense incurred by a Dependent Care FSA Participant for household and dependent care services necessary for gainful employment as provided in Code Section 21(b)(2) in accordance with Code Section 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 Individual” (“QI”) means a qualifying individual as defined in Code Section 21 and includes: (a) a Participant’s tax dependent (as defined in Code Section 152(a)(1), a qualifying child) who is under the age of 13; (b) a Participant’s tax dependent (as defined in Code Section 152, but determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof), who is physically or mentally incapable of self-care, has the same principal place of abode as the Participant for more than half of the year; and (c) a Participant’s Spouse who is physically or mentally incapable of self-care, and who has the same principal place of abode as the Participant for more than half of the year.

Notwithstanding the foregoing, in the case of divorced or separated parents, a Qualifying Individual who is a child shall, as provided in Code Section 21(e)(5), be treated as a Qualifying Individual of the custodial parent (within the meaning of Code Section 152(e)) and shall not be treated as a Qualifying Individual with respect to the non-custodial parent.

“Qualifying Medical Expense” means an expense incurred by a Participant or Eligible Dependent for medical care, as defined in Code Section 213(d), and as allowed under Code Section 105 and the Regulations and not otherwise used by the Participant as a deduction in determining the tax liability under the Code, but excluding (a) premiums for any health insurance plan, policy or contract, (b) long-term care expenses as defined in Code Section 7702B(c), and (c) any expense which has been reimbursed, or is reimbursable, to such Employee or Eligible Dependent from any other source. Qualifying Medical Expenses include expenses incurred on or after January 1, 2020, to purchase over-the-counter medicines or drugs for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or functions of the body, and that otherwise meet all of the requirements of the first sentence of this paragraph. Only reasonable quantities of over-the-counter medicines or drugs of the same kind may be reimbursed from a Participant’s Health Care FSA in a single calendar month. Insulin remains a covered expense. Notwithstanding the foregoing, Qualifying Medical Expenses do not include items that are used to promote the general good health of an individual or items that are not medicines or drugs, except that Qualifying Medical Expenses also include expenses incurred

on or after January 1, 2020, for menstrual care products, as defined in Code Section 223(d)(2)(D) and as authorized under Code Section 106(f).

“Qualified Medical Child Support Order” (“QMCSO”) means a medical child support order that: (a) creates or recognizes the right of an “alternate recipient” to receive benefits for which a Participant or beneficiary is eligible under a group health plan or assigns to an alternate recipient the right of a Participant or beneficiary to receive benefits under a group health plan; and (b) is recognized by the group health plan as “qualified” because it includes information and meets other requirements of the QMCSO provisions in ERISA Section 609(a).

“Regulations” means the applicable regulations issued under the Code by the Internal Revenue Service, or the Public Health Service 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.

“Run Out Period” means the period that begins immediately following the Grace Period and ends on the November 15 following the close of the Plan Year. For the Plan Year beginning July 1, 2009 and ending June 30, 2010 only, “Run Out Period” means the period that begins immediately following the Grace Period and ends on the November 30 following the close of the Plan Year. For the Plan Year beginning July 1, 2019 and ending June 30, 2020 only, “Run Out Period” means the period immediately following the extended Grace Period, beginning on January 1, 2021 and ending on February 28, 2021. For the Plan Year beginning July 1, 2020 and ending June 30, 2021 only, “Run Out Period” means the period immediately following the extended Grace Period, beginning July 1, 2022 and ending on August 31, 2022.

“Salary Reduction” means: (a) the voluntary reduction of an Employee’s Compensation made in consideration of such Employee’s participation in the Premium Only Plan, Flexible Spending Accounts, and/or the Health Savings Account pursuant to an Election; and (b) the dollar amount of such reduction.

“Similar Coverage” means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). Plans offering 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. The Plan may treat coverage by another employer, such as a Spouse’s or Dependent’s employer, as similar coverage.

“Special Enrollment Rights” means those provisions of Title XXVII of the Public Health Service Act, 42 U.S.C. § 300gg, as reflected in Code Section 9801(f) that require group health plans to permit Employees and Eligible Dependents to be enrolled for group Health Insurance Plan coverage following the loss of other health coverage, or if an individual becomes the Dependent of an Employee through birth, marriage, adoption or placement for adoption. Special Enrollment Rights do not apply to Dependent Care FSAs.

“Spouse” means an individual who is treated as a spouse under the Code and, provided that for purposes of this Plan, two individuals are “married” and are in a “marriage” if each is the other’s Spouse. For purposes of the Dependent Care FSA component, a Participant shall not be considered to be married, and shall not be considered to have a spouse if (a) the Participant is legally separated from the Participant’s spouse under a divorce or separate maintenance decree, or (b) the Participant, although married, files a separate federal income tax return, maintains as the Participant’s home a household that is the principal place of abode of a Qualifying Individual

for more than one-half of the calendar year, furnishes over half of the cost of maintaining such household for the calendar year, and, during the last six (6) months of such calendar year, the Participant's spouse is not a member of such household.

“**Student**” with regard to the Dependent Care FSA, 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.

“**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended, and including all Regulations promulgated pursuant hereto.

Article III. Premium Only Plan

Section 3.1 General

The Employer offers contributory, group health insurance coverage for the benefit of its Eligible Employees and their Eligible 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

Participants may voluntarily pay their share of the Premiums for the Health Insurance Plan(s) on a pre-tax basis by electing the Premium Only Plan as provided herein. Alternatively, Employees may pay for their share of the Premiums with after-tax payroll deductions (post-tax premiums) outside of this Plan. Unless an Exception to the Irrevocability Rules authorized under Article VIII applies, the Election to enroll in the Premium Only Plan is irrevocable for the duration of the Period of Coverage.

Section 3.3 Funding of Premium Only Plan

The Employer shall pay the Participant's portion of the Premium for the Health Insurance Plan(s) designated by the Participant on the Election Form and shall reduce such Participant's Compensation by the same amount. In addition, the Employer shall continue to contribute toward the total Premium of the Health Insurance Plan(s) according to the Employer's benefits policies.

Section 3.4 Cessation of Employment

Upon termination of a Participant's employment with all Participating Affiliates and following issuance of such Participant's final payroll check, no further contributions to the Premium Only Plan are allowed. Thereafter, continued coverage under the Health Insurance Plan 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 Section 105, and the Qualifying Medical Expenses reimbursed hereunder are intended to be eligible for exclusion from Participant's gross income under Code Section 105(b).

An Eligible Employee may voluntarily elect to participate by designating the amount to be contributed to a Health Care FSA on the Election Form provided by the Plan Administrator. Unless an Exception to the Irrevocability Rules authorized under Article VIII applies, the Election is irrevocable for the duration of the Period of Coverage.

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.

In addition, certain individuals may receive reimbursement for Qualifying Medical Expenses incurred during the Grace Period immediately following the close of that Plan Year from amounts remaining in their Health Care FSA for that Plan Year in accordance with Section 4.5.

A Participant who has an election under the Health Care FSA will not qualify as an eligible individual for health savings account purposes. In addition, a Participant who has an election for Health Care FSA benefits that is in effect on the last day of a Plan Year cannot elect health savings account benefits for any of the first three (3) calendar months following the close of that Plan Year, (notwithstanding the preceding, for the Plan Year ending June 30, 2020, such Participant cannot elect health savings account benefits until January 1, 2021, and for the Plan Year ending June 30, 2021, such Participant cannot elect health savings account benefits until July 1, 2022) unless the balance in the Participant's Health Care FSA is \$0 as of the last day of that Plan Year. For this purpose, a Participant's Health Care FSA balance is determined without regard to any claims that have been incurred but have not yet been reimbursed (whether or not such claims have been submitted).

Section 4.2 Funding of Health Care Flexible Spending Account

The Employer shall contribute to each Participant's Health Care FSA 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 Maximum and Minimum Contributions

The maximum amount that may be contributed to the Health Care FSA for any Participant for any Period of Coverage shall not exceed \$2,750; the minimum amount shall be \$120. Such maximum amount may be adjusted by the Plan Administrator for any cost-of-living adjustment described in Code Section 125(i)(2). The salary reduction amount so elected shall be funded pro-rata over the number of consecutive pay periods in the Plan Year in a reasonable manner as determined in the sole discretion of the Plan Administrator. If a Participant enters the Health Care FSA mid-year or wishes to increase the Election mid-year as permitted in the Exceptions to the Irrevocability Rules in Article VIII of this Plan, the Participant may elect or increase coverage up to the annual Plan Year maximum prorated over the remaining amounts in the Plan Year, as applicable.

All employers that are treated as a single employer under Code Sections 414(b), (c), or (m), relating to controlled groups and affiliated service groups, are treated as a single employer for purposes of the \$2,500 (as indexed under Code Section 125(i)(2) for cost of-living adjustments for plan years beginning after December 31, 2013) limit. If a Participant participates in multiple cafeteria plans offering health care flexible spending accounts maintained by members of a controlled group or affiliated service group, the Participant's total health care flexible spending account contributions under all of the cafeteria plans are limited to \$2,500 (as indexed under Code

Section 125(i)(2) for cost-of living adjustments for plan years beginning after December 31, 2013). However, a Participant employed by two or more employers that are not members of the same controlled group may elect to contribute up to \$2,500 (as indexed under Code Section 125(i)(2) for cost-of-living adjustments for plan years beginning after December 31, 2013) to each employer's health care flexible spending account.

Section 4.4 Health Care Flexible Spending Account Benefit Maximum

The maximum dollar amount elected by a Participant for Qualifying Medical Expenses during a Period of Coverage pursuant to Article IV (reduced by prior reimbursements during the Period of Coverage) shall be available at all times during the Period of Coverage, regardless of the actual amounts credited to the Participant's Health Care FSA.

Section 4.5 Payment of Benefits

In order to claim reimbursement under the Health Care FSA other than through a debit and/or credit (stored value) card ("debit card"), a Participant must submit a 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. Such bills or proof of Qualifying Medical Expense must show the date the expense was incurred as well as the amount. The Plan Administrator reserves the right to delegate to a claims adjudicator the authority to determine, at its discretion, whether an expense is reimbursable. Each request for reimbursement shall be acted upon and approved or disapproved at least monthly following its receipt by the claims adjudicator, or when the total amount of the claims submitted is at least a reasonable minimum amount, as set by the Plan Administrator. If the Health Care FSA is accessible by a debit card, the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Rev. Rul. 2003-43, IRS Notice 2006-69, Notice 2010-59, Notice 2011-5, and other IRS guidance (collectively "IRS Guidance"). The Plan Administrator shall follow the IRS Guidance in the administration of the use of debit cards for the Health Care FSA.

Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 4.5, an individual may be reimbursed for Qualifying Medical Expenses incurred during a Grace Period from amounts remaining in the individual's Health Care FSA at the end of the Plan Year to which the Grace Period relates ("Prior Plan Year Health Care FSA Amounts") if the individual is either: (a) a Participant with Health Care FSA coverage that is in effect on the last day of that Plan Year; or (b) a Qualified Beneficiary (as defined under COBRA) who has COBRA coverage under the Health Care FSA on the last day of that Plan Year.

- (1) Prior Plan Year Health Care FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Health Care FSA Amounts may not be used to reimburse Qualifying Dependent Care Expenses.
- (2) Qualifying Medical Expenses incurred during a Grace Period and approved for reimbursement in accordance with this Section will be reimbursed first from any available Prior Plan Year Health Care FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year, except that if the Health Care FSA is accessible by a debit card, Qualifying Medical Expenses incurred during the Grace Period may need to be submitted

manually in order to be reimbursed from Prior Plan Year Health Care FSA Amounts if the debit card is unavailable for such reimbursement. An individual's Prior Plan Year Health Care FSA Amounts will be debited for any reimbursement of Qualifying Medical Expenses incurred during the Grace Period that is made from such Prior Plan Year Health Care FSA Amounts.

- (3) Claims for reimbursement of Qualifying Medical Expenses incurred during a Grace Period must be submitted no later than the end of the Run Out Period following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Health Care FSA Amounts.

Section 4.6 Coordination of Benefits With HSA

Health Care FSA Benefits are intended to pay benefits solely for Qualifying Medical Expenses for which Participants have not been previously reimbursed and will not seek reimbursement elsewhere. Accordingly, the Health Care FSA shall not be considered to be a group health plan for coordination of benefits purposes, and Health Care FSA Benefits shall not be taken into account when determining benefits payable under any other plan. Notwithstanding the foregoing, however, in the event that an expense is eligible for reimbursement under both the Health Care FSA and the HSA, the Participant may choose to seek reimbursement from either the Health Care FSA or the HSA, but not both.

Section 4.7 Forfeiture of Account Balance; "Use it or Lose it" Rule

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 to the Health Care FSA after all reimbursements have been made for a Period of Coverage, its related Grace Period and subsequent Run Out Period, the Participant shall forfeit all rights with respect 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. The Participant shall forfeit all rights with respect to such balance.

To the extent contributions are forfeited under the Health Care FSA component of the Plan, such forfeitures may only be used in one or more of the following ways as determined by the Plan Sponsor:

- (a) to offset any losses experienced by the Plan Sponsor or any Participating Affiliate in the Plan as a result of making reimbursements (i.e., providing Health Care FSA Benefits) with respect to all Participants in excess of the contributions made by such Participants through salary reductions and after-tax contributions;
- (b) to defray the reasonable cost of maintaining and administering the Health Care FSA component of the Plan; or
- (c) to use in accordance with Proposed Treasury Regulation Section 1.125-5(o) or successor regulation or guidance;

provided however, in accordance with the provisions of the University of Colorado Health and Welfare Trust, such amounts may not revert to the Plan Sponsor, any Participating Affiliate in the Plan or any Employee.

In addition, any Health Care FSA Benefits that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Qualifying Medical Expense was incurred shall be forfeited and applied as described above.

Section 4.8 Cessation of Participation

An Employee who ceases to be a Participant 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 XII.

Section 4.9 Medical Care Expenses

For purposes of this Article IV, medical care expenses include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, and for treatments affecting any part or function of the body. 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 (or during the Grace Period, if applicable), 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.

Section 4.10 Limitations

In order to be considered a Qualifying Medical Expense, the expense must be excludable from income pursuant to Code Section 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 Section 105, unless that position has been overturned by either the IRS or a court with appropriate jurisdiction.

Section 4.11 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 FSA.

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 Code Section 129.

An Eligible Employee may voluntarily elect to participate by designating the amount to be contributed to a Dependent Care FSA on the Election Form provided by the Plan Administrator. Unless an Exception to the Irrevocability Rules authorized under Article VIII 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.

In addition, certain individuals may receive reimbursement for Qualifying Dependent Care Expenses incurred during the Grace Period immediately following the close of that Plan Year from amounts remaining in their Dependent Care FSA for that Plan Year in accordance with Section 5.5.

Section 5.2 Funding of Dependent Care Flexible Spending Account

The Employer shall contribute to each Participant's Dependent Care FSA the Pre-Tax Contribution designated by the Participant on the Election Form as a Dependent Care FSA Contribution and shall reduce such Participant's Compensation by the same amount.

Section 5.3 Maximum and Minimum Contributions

The maximum amount that may be contributed to the Dependent Care FSA for any Participant in any calendar year is the least of:

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

For purposes of this Section 5.3, earned income means earned income as defined in Code Section 32(c)(2) and includes: (a) wages, salaries, tips, and other employee compensation, plus (b) net earnings from self-employment (within the meaning of Code Section 1402(a)) but determined without regard to the deduction allowed by Code Section 164(f), and (c) 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 Employer for employment-related expenses and amounts paid or incurred by an employer for dependent care assistance to an employee.

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 Plan Year). The Spouse's earned income for the entire calendar year is taken into account, even though the Employee and the Spouse were married for only a part of the Plan Year.

The maximum amount that may be contributed to the Dependent Care FSA for any Participant in any calendar year is \$5,000, the minimum \$120. If the Participant enters the Dependent Care FSA mid-year or increases the Election as permitted under the Exception to Irrevocability Rules in Article VIII of this Plan, the Participant may elect or increase the contribution up to the maximum limit provided in this Section 5.3 prorated over the remaining months in the Plan Year.

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 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 a request for reimbursement (claim form) with 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 and the person(s) on whose behalf Dependent Care Expenses have been incurred. 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, and Social Security number or taxpayer identification number of the person providing the services to which such Qualifying Dependent Care Expenses are attributable and a statement that such expenses have not otherwise been reimbursed and that the Participant will not seek reimbursement through any other source. The Plan Administrator reserves the right to delegate to a claims adjudicator 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 at least monthly following its receipt by the claims adjudicator, or when the total amount of the claims submitted is at least a reasonable minimum amount, as set by the Plan Administrator.

Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 5.5, an individual may be reimbursed for Qualifying Dependent Care Expenses incurred during the Grace Period from amounts remaining in the individual's Dependent Care FSA at the end of the Plan Year to which that Grace Period relates ("Prior Plan Year Dependent Care FSA Amounts") if the individual is a Participant with Dependent Care FSA coverage that is in effect on the last day of that Plan Year.

- (a) Prior Plan Year Dependent Care FSA Amounts may not be cashed out or converted to any other taxable or non-taxable benefit. For example, Prior Plan Year Dependent Care FSA Amounts may not be used to reimburse Qualifying Medical Expenses.
- (b) Qualifying Dependent Care Expenses incurred during a Grace Period and approved for reimbursement in accordance with this Section will be reimbursed first from any available Prior Plan Year Dependent Care FSA Amounts and then from any amounts that are available to reimburse expenses that are incurred during the current Plan Year.
- (c) Claims for reimbursement of Qualifying Dependent Care Expenses incurred during a Grace Period must be submitted no later than the end of the Run Out Period following the close of the Plan Year to which the Grace Period relates in order to be reimbursed from Prior Plan Year Dependent Care FSA Amounts.

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, its related Grace Period and

subsequent Run Out Period, the Participant shall forfeit all rights with respect to such Dependent 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. The Participant shall forfeit all rights with respect to such balance. Forfeited balances may be retained by the Plan Sponsor, or if not retained by the Plan Sponsor may only be used in one or more of the following ways as determined by the Plan Sponsor:

- (a) to offset any losses experienced by the Plan Sponsor or any Participating Affiliate in the Plan as a result of making reimbursements to any Participant in excess of the contributions made by such Participant through salary reductions and after-tax contributions;
- (b) to defray the reasonable cost of maintaining and administering the Dependent Care FSA component of the Plan; or
- (c) to use in accordance with Proposed Treasury Regulation Section 1.125-5(o) or any successor regulation or guidance.

In addition, any Dependent Care FSA Benefits that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Qualifying Dependent Care Expense was incurred shall be forfeited and applied as described above.

Section 5.7 Cessation of Participation

An Employee who ceases to be a Participant 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 the Employee's Dependent Care FSA as of the date the Employee ceases to be a Participant, and only for Qualifying Dependent Care Expenses incurred during 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 QI, 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 Section 21(b)(2) in accordance with Code Section 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 (or Grace Period, if applicable); and
- (e) if expenses are incurred for services provided by a dependent care center that provides care for more than six (6) individuals who do not reside at the facility on a regular basis during the taxable year and receives payment for providing such services, 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 rendered for the month of June are not fully incurred until June 30 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, Domestic Partner or Partner in a Civil Union of the Employee;
- (b) with respect to whom a personal exemption is allowable under Code Section 151(c) either to the Employee or the Spouse for the year; or
- (c) who is a child, adopted child, stepchild, eligible foster child, dependent of a Domestic Partner, or dependent of a Partner in a Civil Union of the Participant who is under the age of 19 at the close of the Plan Year in which the expenses were incurred.

An amount which may constitute an expense otherwise deductible by the Participant under Code Section 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 the Participant's federal income tax return or to the extent that such amount is actually reimbursed to the Participant as a health expense.

In order to be considered a Qualifying Dependent Care Expense, the expense must be excludable from income pursuant to Code Section 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 Section 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 Section 5.3, in the case of a Spouse who is a Student, that Spouse shall be deemed, for each month during which the Spouse 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 QI with respect to the Participant, or
- (b) \$500 if there are two or more QIs with respect to the Participant.
- (c) 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 self-care, that Spouse shall be deemed, for each month during which the Spouse is incapable of self-care, to be gainfully employed and to have earned income of not less than:

- (a) \$250 if there is one QI with respect to the Participant, or
- (b) \$500 if there are two or more QIs with respect to the Participant.
- (c) 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 a QI 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, as defined by the Plan Administrator.

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. On or before January 31 of each year, the Plan Administrator shall provide each Participant with a written statement showing the amount of Qualifying Dependent Care Expenses paid with respect to the Participant during the preceding calendar year, or showing the Salary Reductions for the year for the Dependent Care FSA component, as the Plan Administrator deems appropriate.

Article VI. Health Savings Account

Section 6.1 Establishment

This Health Savings Account ("HSA") is designed to permit an Eligible Employee to contribute on a pre-tax Salary Reduction basis to an Employee's HSA selected by the University of Colorado. The HSA funding feature described in this Article VI is not intended to establish an ERISA plan.

Section 6.2 Definitions

For purposes of this Article and the Plan the terms below shall have the following meaning:

"High Deductible Health Plan" means a high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Employer.

"HSA" means a health savings account established under Code Section 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

"HSA Benefits" has the meaning described in Section 6.3.

"HSA-Eligible Individual" means an individual who is eligible to contribute to an HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

Section 6.3 HSA Benefits

An Eligible Employee can elect to participate in the HSA Benefit by voluntarily electing to make Pre-Tax Contributions on a Salary Reduction basis to such Employee's HSA established and maintained outside the Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Plan). As described in Article VIII, such election can be increased, decreased or revoked

prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed or as soon as administratively practicable thereafter.

HSA Benefits cannot be elected with Health Care FSA Benefits. Also, see Section 4.1 for additional rules that apply when the Participant elected the Health Care FSA Option during the preceding Plan Year.

Section 6.4 Contributions For Cost of Coverage For HSA; Minimum and Maximum Limits

The annual contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant. In no event shall the amount elected and/or contributed by a Participant be less than ten dollars (\$10) per month. Furthermore, in no event shall the amount elected and/or contributed by a Participant exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made.

An additional catch-up contribution of \$1,000 may be made by or for Participants who are age 55 or older by the close of the taxable year.

In addition, the maximum annual contribution shall be:

- (a) reduced by any matching (or other) Employer contributions made on the Participant's behalf (there are currently no such Employer contributions)(other than Pre-Tax Contributions) made under the Plan; and
- (b) prorated for the number of months in which the Participant is an HSA-Eligible Individual.

Section 6.5 Recording Contributions For HSA

As described in Section 6.7, the HSA is not an employer-sponsored employee benefit plan – it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. While the HSA trustee/custodian will be chosen by the Participant, not by the Employer, the University of Colorado may however, limit the number of HSA providers to whom the Employer will forward contributions that the Employee makes on a pre-tax Salary Reduction basis – such limitation is not an endorsement of any particular HSA provider. The Plan Administrator will maintain records to keep track of HSA Contributions an Employee makes on a pre-tax Salary Reduction basis, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer shall have no authority or control over the funds deposited in a HSA.

Section 6.6 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

Section 6.7 Trust/Custodial Agreement; HSA Not Intended to be an ERISA Plan

HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not

this Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan.

The HSA is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified medical expenses" as set forth in Code Section 223(d)(2). The Employer shall have no authority or control over the funds deposited in a HSA. Even though this Plan may allow pre-tax Salary Reduction Contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Article VII. Eligibility and Enrollment

Section 7.1 Eligibility

All Eligible Employees of a Participating Affiliate, as defined in Section 2.1 and described in Appendix I, may participate in this Plan during the time of their employment, subject to the provisions of this Article VII.

Section 7.2 Enrollment in the Plan

Eligible 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. Eligible Employees who fail to submit a timely Election Form will not be permitted to enroll in the Plan until the next Open Enrollment Period.

Section 7.2.1 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 Premiums with Salary Reductions by prospectively designating the Premium Only Plan option of the chosen plan(s);
- (b) Elect to participate in the Health Care FSA and/or Dependent Care FSA by prospectively designating amounts to be contributed to each account; and/or
- (c) Elect to participate in the HSA by prospectively designating amounts to be contributed to such account.

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 VIII applies, shall be irrevocable for the Plan Year, except for an election to participate in the HSA. As described further in Section 8.7, an election to make a contribution to an HSA can be changed at any time on a prospective basis.

Section 7.2.2 New Eligible Employees

New Eligible Employees may elect the Premium Only Plan, establish a Health Care FSA and/or a Dependent Care FSA account within thirty-one (31) days of their date of hire. Newly Eligible Employees may also elect the HSA Benefit as described in Section 6.3. Except as provided in Section 6.3, Elections made by a new Eligible Employee shall be effective the first of the month following the employee's date of hire unless an employee

is hired on the first of the month, then the election becomes effective on the employee's date of hire, provided that a properly completed Election Form is submitted within the allotted time period. Salary Reduction amounts used to pay for such Election must be for compensation not yet currently available on the date of the election. Except as provided in Section 8.7, the Election is irrevocable for the duration of the Period of Coverage unless an exception to the Irrevocability Rules authorized under Article VIII applies.

Section 7.3 Special Enrollment Rights

An Eligible Employee who elects the Premium Only Plan for payment of Health Insurance Plan Premiums, pursuant to Special Enrollment Rights under HIPAA, as referenced in Section 8.5.1, may enroll within thirty-one (31) days of the special enrollment event (or as otherwise provided in Section 8.5.1). An election made by such Participant 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 for such newborn or adopted children 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 accounts.

Section 7.4 Automatic Renewal

A Participant's Premium Only Plan Election will be renewed on an automatic basis each Plan Year unless the Participant revokes the enrollment in writing during the next regularly scheduled annual Open Enrollment Period.

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

Section 7.5 Leave of Absence

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

Section 7.5.1 Paid Leave of Absence

A Participant on paid leave of absence will continue participation in this Plan and be deemed to have no change in 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 7.5.2 General Unpaid Leave of Absence

A Participant on unpaid leave of absence, including FMLA and USERRA, may continue participation in the Plan by paying the applicable Premiums and Pre-Tax Contributions during the leave pursuant to Section 7.5.5. However, expenses for dependent care incurred during such leave may not, in all cases, qualify as Qualifying Dependent Care Expenses under the Dependent Care FSA.

Section 7.5.3 Unpaid Leave Under FMLA

If a Participant takes unpaid leave under 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 Premiums and/or contributions), is entitled to reinstate Benefits coverage following the Participant's return from such leave at the same level or levels in effect immediately prior to taking of the leave, provided the Participant returns from leave during the same Plan Year in which the Participant left. However, Benefits are not payable for expenses incurred during any period for which Premiums and/or required contributions are not paid.

With regard to participation in the Health Care FSA, a Participant whose coverage ceased will be entitled to elect to be: reinstated in the Health Care FSA (a) at the same coverage level as in effect before the FMLA leave (with increased Pre-Tax Contributions for the remaining Period of Coverage), or (b) 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 7.5.4 Unpaid Leave Under USERRA

If a Participant takes an unpaid leave under USERRA, participation will continue in accordance with USERRA for health plan coverage during the unpaid leave for the lesser of: (a) the period of the leave or (b) twenty-four (24) months, provided the required contribution (if any) for such benefits is timely paid by the Participant. If the period of leave is for less than thirty-one (31) days, the required contribution shall be the same contribution as is required for active Employees; if the period of the leave is thirty-one (31) days or longer, the required contribution shall be up to 102% of the full cost of coverage. The Participant must pay the required contribution (if any) as due.

Section 7.5.5 Payment Options during Unpaid Leave

A Participant who continues coverage under the Plan while on unpaid leave of absence may choose from various payment options which may include the following:

- (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 taxable Compensation. Premiums and contributions under the pre-pay option may also be made on an after-tax basis.
- (b) *Pay-as-you-go Option.* Participants may make monthly Premium payments and contributions on an after-tax basis.

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 Medical Leave are payable on the same schedule as would be made if the Participant were not on Family Medical 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 Regulation. The Employer 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 7.6 Absence Due to Disability

A Participant absent from work due to a disability who is: (a) 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 (b) 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 7.5.2 of this Article VII.

Section 7.7 Cancellation of Coverage

Section 7.7.1 Cessation of Required Contributions By A Participant

If a Participant does not make the required Premium or Pre-Tax Contributions 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 7.5.3 as required under FMLA and Section 7.5.4 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 7.7.2 Separation from Service

Upon termination of a Participant's employment with all Participating Affiliates, Salary Reduction will cease. However, Benefits will continue to be available for reimbursement upon receipt of a valid claim for Qualifying Medical Expenses incurred prior to such termination and for Qualifying Dependent Care Expenses incurred prior to the end of the Plan Year. With regard to the Health Savings Account, distributions and all other matters are outside of this Plan and are to be handled by the Participant and the trustee/custodian in accordance with the agreement between them as described in Article VI.

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 XII 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 any Employer 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 any Employer more than thirty (30) days later during that same Plan Year and is otherwise eligible to participate in the Plan, will be allowed to make a new Election, except that if such individual continues coverage under the Health Insurance Plan or Health Care FSA under COBRA during the period between termination and return to employment, the individual's active participation shall be reinstated with no change of coverage or Election.

Article VIII. Election Changes

Section 8.1 Irrevocability of Elections

Except as provided in this Article VIII, Elections made with respect to both the Premium Only Plan 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 8.2 Election Changes

During the Plan Year, a Participant may make a new Election upon the occurrence of certain events as described in this Article VIII, including Elections made under Benefits paid for on a pre-tax basis or through after-tax payroll deductions, 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 8.3 Procedure for Making New Election if Exception to Irrevocability Applies

Except as provided in Section 8.7, a Participant (or Eligible Employee, if applicable) may make a new Election under circumstances described in Sections 8.4 and 8.5 of this Article VIII, as applicable, but only if the Participant (or Eligible Employee, if applicable) submits a new Election Form within thirty-one (31) days of the event (or as otherwise provided in Section 8.5.1) along with documentation that the Plan Administrator deems necessary to verify that the change is permissible under the Plan.

Except as provided in Section 8.5.1 for HIPAA Special Enrollment Rights in the event of birth, adoption or placement for adoption, and as provided in Section 8.7 for Election changes for HSA Benefits, all Election changes shall be effective on a prospective basis only, i.e., no earlier than the first of the month following submission of a properly completed and timely Election Form.

Section 8.4 Exceptions to the Irrevocability Rules - Change in Status

With regard to:

- (a) the Premium Only Plan, coverage under a Health Insurance Plan;
- (b) Health Care FSA; and/or
- (c) 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 8.4.1 and the Change in Status event affects eligibility for coverage under a health or employer benefit plan.

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 8.4.1 Change in Status Defined

With regard to Section 8.4, each of the following events is a Change in Status, but only if it affects eligibility for Benefits:

- (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 Dependents, including birth, death, adoption, and placement for adoption.
- (c) Any of the following events that change the employment status of the Participant, Spouse, or 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 only; (iv) changing from or to temporary and permanent employment; (v) a change in worksite; (vi) a change in employment from a Participating Affiliate to an Affiliate which is not a Participating Affiliate; or (vii) any other change in employment status that affects eligibility for Benefits.
- (d) Events that cause a Participant's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, Student status, or any similar circumstance.
- (e) A change in the place of residence of the Employee, Spouse, or Dependent.

Section 8.4.2 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 8.4.2.

- (a) *Loss of Spouse or Dependent Eligibility (e.g., due to death, change of marital status or attainment of limiting age).* If a former Spouse or Dependent ceases to satisfy the eligibility requirements of a Health Insurance Plan, a Participant may elect to cancel coverage for only the former Spouse or 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 Spouse or 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 or is increased under a Cafeteria Plan or qualified benefit plan of a Spouse's or Dependent's employer that provides Similar Coverage.
- (c) *Special Consistency Rule for Dependent Care FSA Benefits.* A Participant may change or terminate the 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 Section 129.

Section 8.5 Exceptions to the Irrevocability Rules – Other

With regard to the Premium Only Plan, 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 8.5. Notwithstanding the preceding sentence, an Election change due to a Special Enrollment Right under HIPAA may be

retroactive as specified in Section 7.3. An Election change from the Health Care FSA is permitted only upon the occurrence of events described in Sections 8.5.2 and 8.5.3, and an Election change for the Dependent Care FSA is permitted only upon the occurrence of events described in Section 8.5.7.

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 8.5.

Section 8.5.1 Special Enrollment Rights under HIPAA

With respect to the Premium Only Plan, if a Participant, Spouse or Dependent is entitled to Special Enrollment Rights under a group health plan as required by HIPAA in accordance with Code Section 9801(f), the Participant may revoke a prior Election and make a new Election that corresponds with the Special Enrollment Rights.

A Special Enrollment Right arises when (a) an Employee acquires a Spouse or Dependent through marriage, birth, adoption, or placement for adoption, or (b) when the Employee, Spouse, 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 (c) the Employee, Spouse, or Dependent loses coverage in one of the following specific circumstances: (1) if the coverage is not COBRA coverage, the Employee, the Spouse, or the Dependent becomes ineligible for coverage, or (2) if the coverage is COBRA coverage, that coverage is exhausted.

Notwithstanding any contrary provision in this Plan and subject to the conditions of this Section 8.5.1, with respect to the Premium Only Plan, if a Participant or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit) as required by HIPAA under either of the following circumstances, then the Participant may revoke a prior election for such coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment rights:

- (1) The Participant's or Dependent's coverage under a Medicaid plan (as further described in Section 8.5.3) or under a state children's health insurance program (as further described in Section 8.5.8) is terminated as a result of loss of eligibility for such coverage and the Participant requests coverage under the group health plan not later than sixty (60) days after the date of termination of such coverage; or
- (2) The Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan and the Participant requests coverage under the group health plan not later than sixty (60) days after the date the Participant or Dependent is determined to be eligible for such assistance.

An election change under this provision must be requested within sixty (60) days after the termination of Medicaid or state child health plan coverage or the determination of eligibility for a state premium assistance subsidy, as applicable.

Election changes made pursuant to this provision shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change and shall be effective on a prospective basis only.

Tag-along Rule. An Election to add previously Eligible Dependents as a result of the acquisition of a new Spouse, or Dependent shall be consistent with the Special Enrollment Right, in accordance with federal Cafeteria Plan Regulations.

HIPAA relates solely to the addition of coverage under a Health Insurance Plan on the occurrence of a special enrollment event as described above. It does not permit the cancellation of coverage under any circumstances.

Section 8.5.2 Entry of a Qualified Medical Child Support Order

If a QMCSO that satisfies the requirements of Section 609(a) of ERISA, resulting from a divorce, legal separation, annulment, or change in legal custody requires the Eligible Employee's Dependent child or Dependent foster child to be covered under a group Health Insurance Plan and/or the Health Care FSA, the Eligible Employee may make a change in the Election so long as it corresponds with the coverage to be provided to the child or foster 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 8.5.3 Entitlement to Medicare or Medicaid

A Participant may revoke an Election for the

- (a) Premium Only Plan and coverage under a Health Insurance Plan; and
- (b) The Health Care FSA,

if the Employee, Spouse, or Dependent who is enrolled in a Health Insurance Plan and/or Health Care FSA becomes entitled to Medicare or Medicaid, (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines). In addition, if an Employee, Spouse, or Dependent who has been entitled to coverage under Medicare or Medicaid loses eligibility for such coverage, the Employee may make a prospective Election to commence or increase coverage for that Employee, Spouse, or Dependent under a Health Insurance Plan and Health Care FSA and modify or make a corresponding Election. Coverage changes permitted under this Section 8.5.3 shall result in corresponding modifications of an Election on account of and consistent with the change in coverage.

Section 8.5.4 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 (a) permit Participants who are enrolled in any other option to prospectively change to the decreased cost plan, and (b) 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 8.5.4 shall result in corresponding modifications of an Election for the Premium Only Plan 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 8.5.5 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 Premium Only Plan 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 8.5.6 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 coverage under the Health Insurance Plan is significantly curtailed and such curtailment results in loss of coverage, or the Participant's Health Insurance Plan benefit option is withdrawn, Participants may drop coverage if no Similar Coverage is offered.

If coverage under the Health Insurance Plan is significantly improved or if the Plan adds a new Health Insurance Plan benefit option during a Period of Coverage, the Plan Administrator may permit: (a) 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 (b) Employees who are not enrolled to elect the newly-added or significantly improved option on a prospective basis.

Coverage changes permitted under this Section 8.5.6 shall result in corresponding modifications of an Election for the Premium Only Plan 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 8.5.7 Changes Affecting Dependent Care

A Participant may make a prospective Election change to the Salary Reduction for the Dependent Care FSA that is 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 the Dependent Care FSA, but only if the Dependent Care provider is not a relative of the Participant.
- (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 employer's qualified dependent care plan, in accordance with applicable IRS Regulations.

Section 8.5.8 Loss of Coverage Under Other Group Health Coverage.

An Employee may elect to enroll in the Health Insurance Plan or increase the Salary Reduction under the Premium Only Plan if such Employee or 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 ("CHIP") under Title XXI of the Social Security Act;
- (b) a medical care program of an Indian Tribal government (as defined in Code Section 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 8.5.9 Change in Coverage Under Another Employer Plan

A Participant may make a prospective Election change to the Premium Only Plan that is on account of and consistent with a change made under another employer's qualified benefits plan in accordance with applicable IRS Regulations.

Example: Open enrollment for Spouse's employer-sponsored, qualified group health insurance plan is held in July. Spouse enrolls the entire family for the plan year commencing September 1. Participant may make a corresponding Election to drop family medical coverage effective September 1.

The Plan 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 8.5.10 Special Transition Rule for July 1, 2013 Plan Year

Notwithstanding any contrary provision in this Plan, an Employee of the University of Colorado who failed to make a Salary Reduction election under the Plan for the Plan Year commencing July 1, 2013, may make (only once) a prospective Salary Reduction election for the portion of such Plan Year on and after January 1, 2014, with respect to the Health Insurance Plan benefits for medical coverage, without regard to whether the Employee experienced a Change in Status under Section 8.5, if such Employee obtains medical coverage under one of three Health Insurance Plans offered by the Employer (the CU Health Plan – Exclusive, CU Health Plan – High-Deductible or CU Health Plan – Administered by Kaiser Permanente Insurance Company), that is effective on January 1, 2014. Such election may be made beginning November 11, 2013, and ending November 22, 2013.

Section 8.5.11 Special Election Changes Under Notice 2014-55

Subject to (b) and (c) of this subsection, a Participant may prospectively revoke a Salary Reduction election with respect to participation in the medical Health Insurance Plan pursuant to this subsection:

- (a) Effective July 1, 2015, a Participant may prospectively revoke a Salary Reduction election with respect to participation in the medical Health Insurance Plan if:
 - (1) the Participant is eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through a Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or the Participant seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period; and
 - (2) the revocation of the election of coverage under such medical Health Insurance Plan corresponds to the intended enrollment of the Participant, and any related individuals whose medical Health Insurance Plan coverage would cease due to such revocation in a Qualified Health Plan through a Marketplace for new coverage that is effective beginning no later than the day immediately following the last day the original coverage is revoked.
- (b) A Participant must provide reasonable proof that he or she is eligible to revoke a Salary Reduction election described in this subsection at the time he or she makes such revocation.
- (c) The terms "Special Enrollment Period," "Qualified Health Plan," "Marketplace," and "Department of Health and Human Services," where used in this subsection, shall have the meaning given to such terms in Notice 2014-55. This subsection shall be interpreted to be compliant with Notice 2014-55.

Section 8.6 Effect of Change of Coverage During a Period of Coverage

If during a Period of Coverage, a Participant makes a new Election as provided in this Article VIII, 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, and with respect to the Health Care FSA and/or the Dependent Care FSA are reduced by the amount of Qualifying Medical Expenses and Qualifying Dependent Care Expenses incurred and reimbursable prior to the effective date of the change.

With regard to the Health Care FSA, in no event may a new Election be reduced to an amount that is less than the cumulative expenses incurred on or after the first day of the Period of Coverage but prior to the effective date of the new Election.

Section 8.7 Election Changes for HSA Benefits

As set forth in Section 6.3, an election to make a Pre-Tax Contribution to an HSA can be increased, decreased, or revoked at any time on a prospective basis. Such election changes shall be effective no later than the first day of the next calendar month following the date that the election change was filed or as soon as administratively practicable thereafter. No Benefit

Election changes can occur as a result of a change in HSA election except as otherwise described in this Article VIII. For example, a Participant generally would not be able to terminate an election under the Health Care FSA in order to be eligible for the HSA, unless one of the exceptions described in Sections 8.5 for Health Care FSAs otherwise applied.

A Participant entitled to change an election as described in this Section 8.7 must do so in accordance with the procedures described in Section 8.3.

Article IX. Nondiscrimination Provisions

Section 9.1 General.

All employees of the Employer, including leased employees under Code Section 414(n), and employees of related employers must be taken into account to determine whether the Plan meets the applicable nondiscrimination requirements under the Code and this Article.

Section 9.2 Cafeteria Plan.

The Plan shall not discriminate in a manner which violates Code Section 125.

Section 9.3 Health Care FSA Nondiscrimination.

The Health Care FSA portion of the Plan (and any self-insured health plan) shall comply with the nondiscrimination rules under Code Section 105(h) and its Regulations. Contributions which may not be paid because of reductions imposed by these nondiscrimination rules shall be forfeited for the purposes of testing nondiscrimination. For purposes of nondiscrimination testing, the Employer shall include all related employers.

Section 9.4 Dependent Care FSA Nondiscrimination.

The Dependent Care FSA portion of the Plan shall comply with the nondiscrimination rules under Code Section 129 and its Regulations. Contributions which may not be paid because of reductions imposed by these nondiscrimination rules shall be forfeited for the purposes of testing nondiscrimination. For purposes of nondiscrimination testing, the Employer shall include all related employers.

Section 9.5 Nondiscrimination.

The Plan Administrator may reject Elections or reduce contributions and Benefits on a reasonable basis to prevent the Plan from being discriminatory. Contributions which do not comply with nondiscrimination rules shall be taxable as income.

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions (including Salary Reductions for HSA Benefits) for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to:

- (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan;
- (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized;

- (c) maintain the qualified status of benefits received under this Plan; or
- (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans.

In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

Article X. 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.

Article XI. 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 applicable Federal law (including the Code, the Treasury regulations issued thereunder and other guidance issued by the Department of the Treasury (as the same may be issued or amended from time to time), including but not limited to applicable guidance due to the Novel Coronavirus outbreak).

Article XII. COBRA Compliance

Section 12.1 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 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 (taking into account all claims submitted before the date of the Qualifying Event).

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

Section 12.2 Payment

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

Article XIII. HIPAA Compliance for Health Care Flexible Spending Account

Section 13.1 HIPAA Compliance

It is intended that the Health Care FSA meet all applicable requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164) (“HIPAA Regulations”) and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (“HITECH Act”), along with any regulations issued by the Department of Health and Human Services (“HHS”). This Plan is a hybrid entity, as defined by the HIPAA Regulations. The Health Care FSA under this Plan is a health care component of the Plan and subject to the applicable provisions of HIPAA.

The Health Care FSA shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan relating to the Health Care FSA and HIPAA, the provisions of HIPAA shall be deemed controlling, and any conflicting part, clause or provision of the Plan shall be deemed superseded to the extent of the conflict.

The Health Care FSA will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Health Care FSA will use and disclose PHI for purposes related to health care, payment for health care, health care operations, and other disclosures permitted under the HIPAA Regulations.

Section 13.2 Privacy and Security Regulations Compliance

The Plan Sponsor shall adopt policies and procedures to protect the privacy and provide for the security of PHI and electronic PHI as such may be maintained by or disclosed to the Health Care FSA, its duly authorized representatives and business associates in compliance with HIPAA Regulations promulgated thereunder by the HHS and other applicable rules, as amended. The Plan Sponsor shall:

- (a) Not use or further disclose PHI other than as permitted or required by the Health Care FSA component of the Plan document or as required by law;
- (b) Ensure that any agents or subcontractors to whom it provides protected health information received from the Health Care FSA agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI;
- (c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor or the Employer;
- (d) Report to the Health Care FSA any use or disclosure of PHI of which it becomes aware that is inconsistent with the permitted uses or disclosures provided for;
- (e) Make PHI available to comply with HIPAA’s right to access in accordance with 45 C.F.R. § 164.524;
- (f) Make available PHI for amendment, and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- (g) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- (h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Health Care FSA available to the Secretary of the HHS for

purposes of determining compliance by the Health Care FSA with HIPAA's privacy requirements;

- (i) If feasible, return or destroy all PHI received from the Health Care FSA that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;
- (j) Ensure that adequate separation between the Health Care FSA and the Plan Sponsor required by 45 C.F.R. § 164.504(f)(2)(iii) is established;
- (k) Agree that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and summary health information as defined in 45 C.F.R. § 164.504 and used as described in 45 C.F.R. § 164.504(f), and information disclosed pursuant to a signed authorization that complies with the requirements of 45 C.F.R. § 164.508, which are not subject to these restrictions) on behalf of the Health Care FSA, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Health Care FSA, and it will ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the information;
- (l) Ensure that the adequate separation between the Health Care FSA and the Plan Sponsor, required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures; and
- (m) Report to the Health Care FSA any security incident of which it becomes aware.

Section 13.3 Access to PHI Within Employer

Adequate separation will be maintained between the Health Care FSA and Plan Sponsor. The Plan Sponsor will ensure that the provisions of Section 13.3 are supported by reasonable and appropriate security measures to the extent the persons described in the next sentence create, receive, maintain, or transmit electronic PHI on behalf of the Plan. Only the following individuals or classes of employees shall have access to PHI and may use and disclose PHI: (a) any officer or employee of the Plan Administrator, including but not limited to personnel in the University of Colorado System Administration, who performs functions on behalf or related to the administration of the Health Care FSA, such as benefit design and administration, audit, legal, accounting, and systems support; (b) any person or entity (including any employee, authorized agent or subcontractor of such person or entity) that contracts with or through the Plan Sponsor to provide services relating to the Health Care FSA, including but not limited to any third-party administrator, provided a HIPAA-compliant Business Associate Agreement is in place, and (c) any other Employee who needs access to PHI in order to perform Plan administration functions that the Plan Sponsor performs for the Health Care FSA (such as quality assurance, claims processing, auditing, monitoring, payroll, information security, and appeals). If the persons described herein or any other Employees do not comply with the Health Care FSA component of the Plan document, then the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions. The Plan Sponsor shall cooperate with the Health Care FSA to correct and mitigate any such noncompliance.

Section 13.4 Privacy Official and Security Official

The Privacy Official and Security Official shall be responsible for compliance with the Health Care FSA's obligations under this Article and HIPAA. Specific rules regarding the Privacy Official and Security Official follow:

- (a) *Appointment, Resignation and Removal of Privacy Official and Security Official.* The Plan Sponsor shall appoint one or more individuals to act as Privacy Official and Security Official on matters regarding the Health Care FSA. The individual(s) appointed may resign by giving thirty (30) days notice in writing to Plan Sponsor. The Plan Sponsor shall have the power to remove such individual(s) in accordance with HIPAA, federal and state laws.
- (b) *Policies and Procedures.* The Privacy Official, Security Official and Plan Administrator shall from time to time formulate such policies and procedures as they deem necessary for the Health Care FSA's compliance with this Article and HIPAA. No policy or procedure, however, shall amend any substantive provision of the Health Care FSA.
- (c) *Privacy Notice.* The Privacy Official shall be responsible for arranging with the Plan Sponsor, the Plan Administrator, and any third-party administrator for the issuance of, and any changes to, the Privacy Notice under the Health Care FSA.
- (d) *Complaint Contact Person.* The Privacy Official and Security Official shall be the contact person(s) to receive any complaints of possible violations of the provisions of this Article and HIPAA. The Privacy Official and Security Official shall document any complaints received, and the disposition, if any. The Privacy Official shall also be the contact to provide further information about matters contained in the Health Care FSA HIPAA Privacy Notice.

Section 13.5 Certification of the Plan Sponsor

The Health Care FSA (or business associate acting on behalf of the Health Care FSA) shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor to the Privacy Official that the Plan has been amended to incorporate the provisions of 45 C.F.R. Section 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth above and provides adequate firewalls in compliance with HIPAA.

Article XIV. Administration

Section 14.1 Powers of the Plan Administrator

The Plan Administrator shall administer the Plan and shall exercise the powers and discretion conferred on it by the Plan Sponsor under this Plan.

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, solely the Plan Administrator or appropriate delegates, 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 14.2 Account Balance

In accordance with Sections 4.5 and 5.5, a Participant may submit a claim to the Participant's eligible Health Care and Dependent Care FSAs through the end of the Run Out Period following the close of the Plan Year. During that time, proof of Qualifying Medical Expenses and Qualifying Dependent Care Expenses incurred during the specific Plan Year (and the subsequent Grace Period) may be submitted to the Plan Administrator or its agent for payment from the appropriate account. A Participant with any dollar balances in the Health Care and/or Dependent Care FSAs after the Run Out Period shall forfeit all monies remaining in the account(s). Forfeited balances shall be used in accordance with Sections 4.7 and 5.6.

Section 14.3 Errors

Participants are responsible for reviewing their Election Forms and Confirmation Notices and for reporting errors to the Plan Administrator within a reasonable time period before the commencement of the Plan Year. A Participant shall be permitted to submit a corrected Election Form within a reasonable time period before the commencement of the Plan Year. In the case of a new Employee or new Election, a corrected Election Form will not be accepted once the Period of Coverage begins.

Discrepancies between the submitted Election Form and the electronic payroll record arising from scanning or input errors 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.

Section 14.4 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, retroactively terminate coverage and refuse to honor any claim under the Plan for the Participant, Spouse and/or Dependent related to the person submitting the falsified information.

Section 14.5 Trust

The University of Colorado Health and Welfare Trust (“Trust”) shall hold all contributions from the Health Care FSA and Pre-Tax Contributions for the University of Colorado Health and Welfare Plan, which does not include the contributions to an Employee’s HSA. The Plan shall utilize the trust provisions contained in the Trust Agreement, which shall be incorporated herein by reference.

Article XV. General Provisions

Section 15.1 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 15.2 Compliance

It is intended that this Plan meet all applicable requirements of the Code and all Regulations issued thereunder and any other applicable state and federal law. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and any other applicable state and federal law, the provisions of the Code and any other applicable state and federal law 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 15.3 Effect of Compliance

The Plan Administrator reserves the right to reverse or modify a Participant’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 Plan Year. Employees will be notified within sixty (60) days of the time any necessary modification of their Salary Reduction occurs.

Section 15.4 No Guarantee of Tax Consequences

The Employer and the Plan Administrator make no guarantee 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 15.5 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 15.6 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 15.7 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 Employer and an Employee; or
- (b) Give an Employee the right to be retained in the employ of the Employer; or
- (c) Interface with or diminish the right of the Employer to discharge an Employee at any time; or
- (d) Give the Employer the right to require an Employee to remain in its employ or interfere with the Employee's right to terminate employment at any time.

Section 15.8 Number and Gender

Unless otherwise indicated by the context, terms used in the singular also include the plural and vice versa; and terms using any gender shall be interpreted to mean any or all genders.

Section 15.9 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.

Section 15.10 Counterparts and Delivery

The Plan and any amendments thereto may be executed by electronic signature and in multiple counterparts and may be delivered by fax and other electronic means, all of which shall be deemed to be originals and all of which shall constitute one document.

Section 15.11 Use of Electronic Media

Telephonic or electronic media may be used to satisfy any notice or consent requirement to or from a Participant or beneficiary, and to conduct plan transactions such as enrolling Participants, making (and changing) Participant contribution elections, and other transactions.

Section 15.12 Special Provisions

Notwithstanding anything in the Plan to the contrary, and to the extent required by applicable law, to the extent a Participant is permitted to enroll a person in a benefit provided through the Health Insurance Plan(s), and such person is not the Participant's Spouse under the Code or Dependent under Code Section 152 (as modified by Code Section 105(b)), the fair market value of coverage for such person, less the amount paid for such coverage by the Participant on an after-tax basis,

shall be included in the Employee's gross income. Any provision of the Plan related to a person who is not a Participant's Spouse under the Code or Dependent under Code Section 152 (as modified by Code Section 105(b)) is described herein solely for administrative convenience and is made outside of the Plan.

Article XVI. Appeals

Section 16.1 Appeal From Denial of Claims

Claims for reimbursement of Qualifying Medical Expenses and Qualifying Dependent Care Expenses must be filed along with proof to substantiate the claim with the claims adjudicator 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 claims adjudicator, the claimant shall be given notice by the claims adjudicator 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 the claimant's authorized representative by filing with the Plan Administrator, within sixty (60) days of the date of the notice, a written request for such review; and
- (e) If such request is so filed, the claimant or authorized representative may review pertinent documents and submit issues and comments in writing within the same sixty (60) day period specified in Section 16.1(d) above.

The decision of the Plan Administrator shall be made promptly, and not later than forty-five (45) days after the receipt of the request for 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 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. The claimant shall be given a copy of the decision promptly. For the Premium Only Plan for medical, vision, and dental benefits and the Health Care Flexible Spending Account, the full and fair review shall be made by the Assistant Vice President, CU Health Plan Administration. For the Dependent Care Flexible Spending Account, the full and fair review shall be made by the Assistant Vice President, Employee Services.

Section 16.2 Appeal from Denial of Enrollment, Election or Change Request

Requests for enrollment, election and change requests must be submitted in accordance with the applicable administrative procedures and directives established by the Plan Administrator. If any application for enrollment, election, or change request is wholly or partially denied by the Plan Administrator or its agent, the applicant or Participant may file with the Plan Administrator within sixty (60) days of the date of the denial notice, a written request for a full and fair review of the decision. For the Premium Only Plan for medical, vision, and dental benefits and the Health Care

Flexible Spending Account, the full and fair review shall be made by the Assistant Vice President, CU Health Plan Administration. For the Dependent Care Flexible Spending Account, the full and fair review shall be made by the Assistant Vice President, Employee Services.

Section 16.3 Appeal from Decision of the Plan Administrator

In the event a Participant's appeal is denied by the Plan Administrator pursuant to Sections 16.1(d) and/or 16.2 above, the Participant may appeal to the (a) Associate Vice President, Chief Plan Administrator, CU Health Plan for the Premium Only Plan for medical, vision, and dental benefits and the Health Care Flexible Spending Account, and (b) the Associate Vice President, Employee Services for the Dependent Care Flexible Spending Account (collectively the "Final Reviewer") in writing within sixty (60) days of the date of the denial notice. The Final Reviewer will issue a final written decision within ninety (90) days from receipt of the appeal. The Final Reviewer's decision is final and binding upon all parties including the Employer, the Participant, Spouses and Dependents, their respective families, dependents, successors, assigns, executors, administrators, and legal representatives.

Article XVII. Amendment and Termination

Section 17.1 Amendment and Termination of the Plan

The Plan Sponsor expects the Plan to be permanent, but since future conditions cannot be anticipated or foreseen, the Employer must necessarily and does hereby reserve the right to amend, modify, or terminate the Plan, in whole or in part, at any time, provided the University of Colorado and UPI must unanimously agree on any changes and/or the Plan termination unless the change only impacts the University of Colorado or UPI's Employees and former Employees and covered dependents in which case only the University of Colorado or UPI must agree to the change. The Plan Sponsor 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 Participating Affiliates authorize the Plan Sponsor to amend or terminate the Plan on their behalf as specified in the first sentence. The Plan shall not be used for or diverted to purposes other than for the exclusive benefit of Participants or their Eligible 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.

This Plan is executed as follows:

Plan Sponsor:

**The Regents of the University of Colorado,
a body corporate and a state institution
of higher education of the State of Colorado**

DocuSigned by:
Mark Kennedy
By: _____
0333806F8DC045F...
Mark Kennedy
President

Date: 6/30/2021

Participating Affiliate:

University Physicians, Incorporated

DocuSigned by:
Brian T. Smith
By: _____
A179B03A2BC5439...
Brian T. Smith
Executive Director

Date: 6/24/2021

For Legal Sufficiency:

DocuSigned by:
Melissa Martin
By: _____
B4140CF86C15499...
Melissa Martin
Senior Associate University Counsel

Date: 6/24/2021

APPENDIX I

Eligibility for Participating Affiliates

A. University of Colorado

The eligibility matrix for the University of Colorado is hereby incorporated by reference and any change in eligibility in the matrix is deemed to be an amendment made by the University of Colorado. The matrix can be found at <https://www.cu.edu/docs/benefit-eligibility-matrix>.

B. UPI

All regular employees who have a FTE status of .5 or more, and are on University Physicians, Incorporated's monthly pay cycle. Temporary employees are not eligible.

ACKNOWLEDGEMENT OF RECEIPT

This acknowledges receipt and acceptance of The University of Colorado Flexible Benefits Plan (Amended and Restated July 1, 2021).

**University of Colorado
Health and Welfare Trust**

DocuSigned by:
Todd Saliman
By: _____
Todd Saliman
Chairperson, Trust Committee

Date: 6/24/2021