***July 1, 2023 Update**: See the Summary of Plan Changes (SPC) attached to this EPS for a description of changes that have been made to the Plan effective after July 1, 2020.*

DENVER PUBLIC SCHOOLS

EMPLOYEE BENEFIT PLAN

Employee Plan Summary

July 1, 2020

(Rev. 7/1/22 to update contact information)

Solicitud de Información en Español (Spanish Language Offer of Assistance). Este documento del plan está escrito en inglés y contiene un resumen de sus derechos y beneficios bajo este plan de salud y bienestar. Si tiene dificultades para comprender alguna parte de este documento del plan, comuníquese con el Director de Beneficios al 720-423-3864 (durante las horas normales de trabajo) para obtener ayuda.

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PLAN INFORMATION

This document, when incorporated with the benefit booklets and certificates, and provider contracts, policies, and descriptions ("Benefit Documents"), constitutes this Plan's Employee Plan Summary ("EPS"). This EPS outlines your rights and responsibilities under the Plan and reflects the Plan's benefits ("Component Plans") as of July 1, 2020, which may change from time to time. You should keep this EPS with the Benefit Documents provided to you upon enrollment in each Component Plan. You also should share this EPS with any family members you have elected to cover under the Plan.

Plan Name:	Denver Public Schools Employee Benefit Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	July 1 through June 30 of the following calendar year
Effective Date of this EPS:	July 1, 2020
Original Effective Date of Plan:	July 1, 1930
Funding Method:	Funded through fully-insured contracts and self-insured arrangements
Source of Contributions:	From the School's general assets and employee contributions, when required by the School in its sole discretion
Plan Sponsor and Plan Administrator:	Denver Public Schools 1860 Lincoln Street, 11th Floor Denver, CO 80203 720-423-3864
Plan Sponsor's Employer Identification Number:	84-6001099
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Claims Administrators:	See Appendix B or the Benefit Documents associated with each Component Plan

For additional information regarding the Plan, contact the School's Benefits Administrator at 720-423-3864 or derek_bell@dpsk12.org or refer to the Benefit Documents for each applicable Component Plan. Copies of the Benefit Documents are available free of charge from the School on request.

INTRODUCTION

Establishment and Purpose

Denver Public Schools ("the School") maintains the Denver Public Schools Employee Benefit Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses and eligible dependents.

These benefits are provided under various insurance contracts entered into between the School and insurance companies or service providers ("Issuers"), as well as through self-insured plans funded by the general assets of the School. The Benefit Documents for each Component Plan are incorporated herein by reference only to the extent they provide detailed descriptions regarding each Component Plan's eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. This Employee Plan Summary ("EPS") is not intended to give any substantive rights to benefits that are not already provided for in the Plan and the applicable Benefit Documents. Accordingly, if the terms of this EPS conflict with the terms of the Plan-related Benefit Documents, the terms of the Plan-related Benefit Documents will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this EPS with respect to the legal compliance requirements of any federal law, this EPS will control, unless superseded by applicable law.

Benefits

The Benefit Documents provided to you upon enrollment in the Component Plans listed in Appendix A will contain a complete description of the benefits available under this Plan and any limitations or exclusions applicable to those benefits.

For purposes of the Component Plans that qualify as group health plans, the applicable Benefit Documents describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. The directory of participating network providers is available free of charge by contacting the applicable Issuer at the website or member services phone number provided in the Issuer's Benefit Documents. The Issuer can also provide you with information on any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Component Plan.

Flexible Spending Plan. The School maintains a flexible spending plan that allows you to set-aside pre-tax dollars to pay for qualified health care expenses ("Health FSA") and/or qualified dependent care expenses ("Dependent Care FSA"). Review the FSA's separate summary plan description or other Benefit Documents for additional details on your FSA benefits.

Collectively-Bargained Benefits

Most School employees are represented by an employee association (also known as a bargaining unit or union). The Plan benefits described in this EPS are maintained pursuant to the collective bargaining agreement for all such employee associations. A copy of the collective bargaining agreement applicable to your benefits may be obtained upon your written request to the School:

Denver Public Schools
Attn: Benefits Administrator
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864

The collective bargaining agreements are also available for review during normal business hours at the School's Benefits Department.

Eligibility Rules

Please refer to Appendix C of this EPS to determine your and your dependents' eligibility for participating in the Component Plans. The specific Benefit Documents for the Component Plans may contain additional requirements with regard to dependent eligibility for such Component Plans and the terms under which you and your dependents may participate.

Eligibility Not Based on Health-Related Factors. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits the Component Plans that are group health plans from discriminating with regard to eligibility, premiums, or contributions on the basis of specified health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

Eligibility Not Based on Pre-Existing Conditions. The Patient Protection and Affordable Care Act (often shortened to the Affordable Care Act) ("ACA") generally prohibits the Component Plans that are group health plans

from denying coverage or excluding specific benefits from coverage due to an individual's pre-existing condition. A pre-existing condition includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Misrepresentation or Fraud. In the event a participant obtains benefits wrongfully due to intentional misrepresentation or fraud, the Plan Administrator, claims administrators, and Issuers/contract administrators reserve the right, to the extent permitted by law, to terminate a participant's benefits, deny future benefits, take legal action against such participant, and/or offset from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan.

Employee Contributions

The School, at its discretion, may require employee contributions as a condition of participation in any Component Plan. Each year, the School will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. You will be notified of any required contribution amounts in your enrollment materials prior to each Plan Year. You also may request a copy of any required contribution amounts from the Plan Administrator.

Pre-Tax Contributions. The School may administer the Plan in accordance with Internal Revenue Code Section 125 and underlying regulations. This enables you to pay your share of premiums for certain Component Plans on a pre-tax basis, thereby lowering your cost to participate in the Plan. Note that you do not pay Social Security taxes on the pre-tax dollars used, which could result in a small reduction in your Social Security benefits at retirement.

Recovery of Overpayment. You must immediately repay any excess payments or reimbursements paid to you by the Plan in error. You must reimburse the School for any liability the School may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may reduce or suspend any further payments due or future benefits otherwise payable to you under the Plan and may take any other actions as may be permitted by applicable law, including offsetting your salary or wages accordingly.

Enrollment and Elections

Initial Enrollment. If you are eligible to participate in the Plan, you can become a participant by properly and timely completing an enrollment form or enrolling online, if applicable. If you do not timely enroll when you are first eligible, you must wait until the next open enrollment period unless one of the events permitting a change in your benefit elections occurs first.

Annual Open Enrollment. You may change your benefit elections (or enroll in the Plan if you did not enroll when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year depending on the policies adopted by the School.

Special Enrollment. You may change your elections regarding the medical plan if you have a special enrollment right and you timely notify the School. See the section called "Special Enrollment and Coverage Rights" below for more information.

Changing Elections. Federal law generally requires that an election made under the Plan remain in effect without modification for the entire Plan Year for which the election is made. You may, however, be able to revoke or change an election on account of, and consistent with, one of the "Qualifying Life Events" adopted by the School, as permitted by federal law. Any election made on an after-tax basis may be changed in accordance with the School's policy or any applicable Component Plan limitation.

See the "Permissible Election Changes" section of this EPS for a list of Qualifying Life Events. See the "Special Enrollment and Coverage Rights" section below for additional details on HIPAA special open enrollment rights.

Special Enrollment and Coverage Rights

HIPAA Special Enrollment Rights

Group health plans must provide special enrollment opportunities to certain employees, dependents, and qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Special enrollment is available in the following situations:

- The acquisition of a new spouse or dependent;
- A loss of other coverage in another group health plan, health insurance, Medicaid, or CHIP; or,

- Becoming eligible for a state premium assistance subsidy.

Special enrollment rights do not apply to "limited scope" dental or vision benefits or certain Health FSAs.

If you or your dependents become eligible for special enrollment and properly enroll in coverage during such special enrollment period, coverage generally will begin no later than the first day of the calendar month following a timely enrollment request. However, if the special enrollment event is the birth of a newborn, or the adoption or placement for adoption of a dependent child, coverage will begin as of the date of birth, adoption, or placement for adoption. Any requests for special enrollment or to obtain more information should be directed to:

Denver Public Schools
Attn: Benefits Administrator
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864

If you decline to enroll during the special enrollment period, you may be required to wait until the Plan's next annual open enrollment period to elect coverage.

Adding a New Spouse or Dependent. If your family grows as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Loss of Other Coverage in another Group Health Plan, Health Insurance, Medicaid, or CHIP. If you or your dependents were otherwise eligible to enroll in the Plan but declined coverage due to enrollment in another group health plan, health insurance, Medicaid, or Children's Health Insurance Plan ("CHIP"), you may be able to enroll yourself and your dependents in the Plan mid-Plan Year provided that you request coverage within the following timeframes:

- Within 30 days after your or your dependent's other group health/health insurance coverage ends due to a loss of eligibility (or if the other employer ceases to make contributions toward such coverage);
- If your or your dependent's other coverage is COBRA continuation benefits, within 30 days after the exhaustion of the entire applicable COBRA continuation period; or,
- Within 60 days after your or your dependent's Medicaid or CHIP coverage ends due to a loss of eligibility under the applicable program.

Becoming Eligible for a State Premium Assistance Subsidy. If you or your dependents are eligible to enroll in the Plan while simultaneously being eligible to enroll in Medicaid or CHIP, your state of residence may offer a premium assistance program ("PAP") that can help you pay for Plan coverage that would otherwise be unaffordable to you.

Once you or your dependents are accepted into your state's PAP, the School must allow you to enroll in the Plan mid-Plan Year provided that you request coverage within 60 days of being determined eligible by the PAP.

For more information on the PAP or PAPs that may be available to you and your dependents as of July 31, 2020, go to:

Colorado:
Health First Colorado Website: https://www.healthfirstcolorado.com/
Phone: 1-800-221-3943/State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Phone: 1-800-359-1991/State Relay 711
Health Insurance Buy-In Program (HIBI):
https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
Phone: 1-855-692-6442

The list of states that offer PAPs is updated bi-annually by the Department of Labor ("DOL"). To review the current list of states, go to https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. You also can contact the DOL at www.askebsa.dol.gov or call 1-866-444-EBSA (3272) for more information on Medicaid, CHIP, and PAPs.

Determine Your Medicaid/CHIP Eligibility. If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible, contact your state's Medicaid or CHIP office or call 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply, including in the state's PAP (if available).

Coverage Options Available Through the Exchange. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for a PAP, but you may be able to buy affordable individual insurance coverage through a Health Insurance Marketplace ("Exchange"). For more information on the coverage options available to you through the Exchange, go to www.healthcare.gov.

Dependent Coverage under a National Medical Support Notice

The Plan may be required to cover your child(ren) due to a National Medical Support Notice ("NMSN") even if you have not enrolled the child in the Plan. An NMSN is a standardized medical child support order used by state child support enforcement agencies to obtain group health coverage for children. For additional detail, contact the School's Benefits Administrator at 720-423-3864.

Continuation of Coverage Rights

See the "Continuation of Coverage Rights" section of this EPS for additional details on a participant's right to continue certain health care benefits under the Plan for a limited period of time following a loss of coverage due to a qualifying event such as voluntary or involuntary job loss, reduction in work hours, death, divorce, or other life events.

Cessation of Participation

Unless otherwise stated in the applicable Benefit Documents, your coverage will cease upon the earliest of the following:

- The date or end of the month (as applicable under each Component Plan) in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment, or it may result because you average less than 130 hours of service per month during a Standard Measurement Period and are not eligible for benefits during the Standard Stability Period;
- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Employees on Military Leave" section; or,
- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of contributions by the School.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Documents for the Component Plan. In addition, their coverage will terminate:

- The date or end of the month on which your covered spouse or child is no longer considered an eligible dependent;
- The date, end of the month, or end of the Plan Year in which your dependent child attains a Component Plan's limiting age (unless the Component Plan allows for the continuation of coverage for a mentally or physically disabled child who is primarily dependent on you for support);
- The end of the pay period in which you stop making contributions required for dependent coverage; or,
- The date that a child is no longer covered under a NMSN, if the child is not otherwise eligible to participate in the Plan.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) may have the right to continue health coverage temporarily under COBRA. See the "Continuation Coverage Rights" Section of this EPS for additional details.

PERMISSIBLE ELECTION CHANGES

You generally cannot change your benefit elections under the Plan or vary the salary reduction amounts that you have selected during the Plan Year. However, you may revoke a benefit election (including, but not limited to, an election not to receive benefits under the Plan) after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year if both the revocation and new election are on account of and consistent with a Qualifying Life Event (as described below).

Election and salary reduction changes shall be effective on a prospective basis only (i.e., election changes will generally become effective no earlier than the first day of the next calendar month following the date that the election change request was filed), except that an election change on account of a HIPAA Special Enrollment Right, attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively back to the date of the qualifying event.

If you undergo a Qualifying Life Event, you must inform the Plan Administrator and complete the required change-in-coverage enrollment materials within 30 days after the occurrence of the Qualifying Life Event (or within 60 days in the case of a Special Enrollment Right due to loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage).

In the event of a conflict between the following provisions and the Internal Revenue Code ("IRC") Section 125 plan adopted by the School, the IRC Section 125 plan shall control. The Plan Administrator reserves the right to determine whether an Employee has experienced a Qualifying Life Event and whether the Employee's requested election is consistent with such event.

Change of Status

Qualified Life Events include a change of status due to one of the following events permitted under the rules and regulations adopted by the Department of the Treasury, but only if the Qualifying Life Event changes the individual's eligibility for the applicable benefit. These change in status rules apply to elections for all qualified benefits (e.g., accident or health coverage, group term life, Health FSA, Dependent Care FSA), except that election changes are generally not permitted for Health FSA or Dependent Care FSA benefits if the Qualifying Life Event is a change in residence:

- **Legal Marital Status**. Events that change an employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation, and annulment.
- **Number of Dependents**. Events that change the number of employee's dependents, including following birth, death, adoption, placement for adoption.
- **Employment status**. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; or a change in worksite. In addition, if the eligibility conditions of this Plan or other employer-sponsored plan of the employee, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status, or any similar circumstance.
- **Residency Change**. A change in the place of residence of the employee, spouse, or dependent that results in a loss of coverage (e.g. relocates outside the current plan's service area).
- **Qualifying Dependent**. For the Dependent Care Assistance Plan only, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a Qualifying Life Event.

HIPAA Special Enrollment Rights

Notwithstanding other Qualifying Life Events, an employee may change an election for group health coverage during a Plan Year and make a new election that corresponds with the Special Enrollment Rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP), provided that the employee meets the notice requirements. Special enrollment rights can occur when:

- An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage.
- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption.
- An individual loses coverage under a CHIP or Medicaid or becomes eligible to receive premium assistance under those programs for group health plan coverage.

ACA Marketplace/Exchange Enrollment

Qualified Life Events include the opportunity to enroll in the ACA Marketplace/Exchange or other Minimum Essential Coverage per IRS Notice 2014-55. These Qualifying Life Events apply to elections for group health plan coverage that is not Health FSA benefit coverage and that provides minimum essential coverage under the ACA:

- **ACA Marketplace/Exchange Election**. An employee may elect to cancel contribution for and payment of the employee-paid portion of the group health plan premiums if (1) the employee is eligible for a special enrollment period to enroll in a "qualified health plan" through a Marketplace established under Section 1311 of the ACA or the employee seeks to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.
- **ACA Reduction in Hours**. An employee may elect to cancel contribution for and payment of the employee-paid portion of group health plan premiums if (1) the employee had been reasonably expected to average at least 30 hours of service per week and subsequently moves to a position in which he or she is reasonably expected to average less than 30 hours of service per week, even if that reduction in hours of service does not result in the employee ceasing to be eligible under the employer-sponsored group health plan; and (2) the revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the employee (and any covered dependents), in another plan that provides Minimum Essential Coverage with the new coverage effective no later than the first day of the second month following the month in which the original coverage is revoked.

Change in Cost of Coverage

A change in cost or coverage, as follows, may allow an election change. The following Qualifying Life Events do not apply to the election of Health FSA benefits:

- **Change in Coverage under Another Employer's Plan**. The plan permits participants to make a new election if there is a change in coverage (for the employee, the employee's spouse/domestic partner, or the employee's dependent) under a plan provided by another employer. The employee's new election must be on account of the change in the other employer's plan and correspond with that change. Among other things, this rule permits employees to make election changes during another plan's open enrollment period.
- **Significant Coverage Decrease with or without Loss of Coverage**. If the coverage under a benefit is significantly curtailed or ceases during a Plan Year, affected employees may revoke their elections of such benefit and, in lieu thereof, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- **Significant Improvement or Addition of a New Benefit**. If, during the period of coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then the affected employees may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, those eligible employees who are not participating in the Plan may opt to become participants and elect the new or newly improved benefit package option.
- **Significant Cost Increase**. If the cost of a benefit option increases significantly, the Administrator shall permit the affected employees to either make corresponding changes in their payments or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.
- **Significant Cost Decrease**. If the cost of the benefit option decreases significantly, the Administrator shall permit the affected employees to make corresponding changes in their payments. In addition, any eligible employees not enrolled in the Plan may elect coverage under the corresponding benefit package.

- In addition, if the expenses for a Component Plan increase or decrease during a Plan Year, the Plan may automatically increase or decrease the required periodic contribution of all affected participants accordingly for such health insurance benefits.

Other Situations

Other situations that may permit an election change:

- **Court Order**. A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order as defined in Section 609 of the Employee Retirement Income Security Act of 1974, as amended) that requires accident or health coverage for an employee's child or for a foster child who is a dependent of the employee. The employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.
- **Entitlement to Medicare or Medicaid**. If an employee or an employee's spouse or dependent who is enrolled in an employer-sponsored accident or health plan becomes enrolled under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 of the Social Security Act (the program for distribution of pediatric vaccines), the employee may make an election change to cancel or reduce coverage of that employee, spouse, or dependent under the employer-sponsored accident or health plan. In addition, if an employee or an employee's spouse or dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the employee may make an election to commence or increase his or her coverage or the coverage of his or her spouse or dependent, as applicable, under the School's accident or health plan.
- **Loss of Coverage under Health Plan of a Governmental or Educational Institution**. If an employee or an employee's spouse or dependent is enrolled in a group health coverage sponsored by a governmental or educational institution, the employee may make an election change to add coverage under a corresponding School plan. Group health coverage sponsored by a governmental or educational institution includes (but is not limited to) coverage under: a state children's health insurance program (SCHIP); a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; and a foreign government group health plan.
- **FMLA Leaves of Absence**. A participant may revoke coverage or continue coverage but discontinue payment of his or her share of the cost for group health plan coverage during the period of a leave of absence under FMLA. An employee who revokes coverage shall be entitled to reinstate coverage upon returning from a leave of absence under FMLA.
- **COBRA Premiums**. If the employee or the employee's spouse or dependent becomes eligible for continuation coverage under an employer's group health plan as provided in Code section 4980B or any similar state law, the employee may elect to increase contributions under the Plan in order to pay for the continuation coverage.
- **Correcting Discrimination Issues under the Code**. If the School determines before or during a Plan Year that the Plan or one of its Component Plans will fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, the School may decrease or revoke the elections of affected highly compensated or key employees to ensure compliance with such nondiscrimination requirements or benefit limitation.

COVERAGE DURING A LEAVE OF ABSENCE

You may be eligible to continue certain Plan benefits for yourself and your covered dependents for a period of time during an approved voluntary or involuntary leave of absence, subject to the leave policies and procedures adopted by the School and to the extent prescribed by law. The type of leave you take determines the cost of your benefits (i.e., whether you can continue to pay the same contribution amounts toward your coverage or will need to pay the full premium cost). If you elect not to continue your benefits during your approved leave of absence or if you fail to timely pay for your benefits, your benefits may terminate for the duration of your leave.

Please refer to the School's leave policies and procedures for a description of the different types of leaves of absence available, the maximum length and types of benefits available while on a leave of absence, employee contributions requirements, and the procedures for paying your share of premiums.

Family and Medical Leave Act

In the event the School employs 50 or more individuals within a 75-mile radius, the School will be subject to the Family and Medical Leave Act of 1993 ("FMLA"). FMLA generally allows eligible employees to take a specific amount of job-protected, unpaid leave for certain family and medical reasons specified under the law and its regulations, as amended from time to time.

If you take FMLA leave, you may continue your group health care coverage under the Plan (e.g. medical, dental, vision, Health FSA) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave.

- If you are being paid directly by the School and you substitute accrued paid leave for some of your unpaid FMLA leave days (e.g. both types of leaves run concurrently), your share of premiums will continue to be deducted from your pay (on a pre-tax basis, if applicable).
- If you take an unpaid leave of absence that qualifies under FMLA, you may continue to maintain your health care benefits on the same terms and conditions as though you were still an active employee by paying any normally required contributions for your health care benefits in accordance with the School's FMLA policies and applicable law. If you do not make such payments, or do not make them in a timely manner, your health care coverage may cease. At least 15 days before cessation of your health care coverage, you will be provided with notice of the cancellation. Unless the School has adopted a longer grace period, you will have 15 days from the date of the notice to make the required payment.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions, including any catch-up payments attributable to the period prior to your return from leave, if applicable. If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections.

If you do not return to work at the end of your FMLA leave you may be entitled to COBRA continuation coverage. You also may be required to reimburse the School for the cost of coverage provided to you while you were on unpaid FMLA leave (the cost equals the COBRA premium, without a 2% add-on), unless your failure to return to employment is due to a serious health condition, the need to care for a servicemember, or because of other circumstances beyond your control.

For additional information on FMLA leave, and for information on participant contributions to Plan coverage during FMLA leave, please contact the Plan Administrator.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take a military leave under USERRA, whether for active duty or for training, you are entitled to extend your health care coverage (e.g. medical, dental, vision, Health FSA) for up to 24 months as long as you give the School advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). Your total leave, when added to any prior periods of military leave from the School, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit. Additionally, the

maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (and any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated (e.g. you do not elect the extended coverage), when you return to work with the School you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health care coverage under the Plan.

If you do not return to work at the end of your military leave you may be entitled to continue coverage under COBRA continuation coverage for the remainder of the COBRA continuation period, if any. Any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible.

These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Applicable State or Municipal Law

The School shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

College Student Medical Leave ("Michelle's Law")

To the extent any Component Plan is a group health plan that requires certification of student status in order to maintain a dependent child's coverage, the Plan shall comply with Michelle's Law. A dependent child enrolled in an institution of higher education who loses his or her student status due to a medically necessary leave of absence shall be allowed to continue such Component Plan coverage for up to one year as measured from the first day of the leave of absence or from the date coverage would otherwise terminate due to the loss of student status, whichever is earlier.

The Plan must receive written certification from the child's physician confirming the serious illness or injury and the medical necessity of the leave or change in enrollment status (e.g. a switch from full-time to part-time student status).

CONTINUATION OF COVERAGE RIGHTS

In the event the School employs 20 or more employees in the preceding year, the following federal COBRA provisions apply to certain Component Plans that are group health plans (e.g., medical, dental, vision, Health FSA). Nothing in this section is intended to expand your rights beyond COBRA's requirements or the requirements of any other applicable federal or state law.

COBRA Coverage is a continuation of the Plan's COBRA-eligible benefits when your coverage would otherwise end due to a life event known as a "qualifying event" (as described below). After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary," which may include you, your spouse, and/or your dependent children. If elected, you must pay the full cost of the COBRA Coverage (including both employer and employee contributions) as described in the "Cost of COBRA Coverage" section.

If you are interested in receiving more information about your COBRA rights and obligations under the Plan, contact the School's Benefits Administrator at 720-423-3864.

Other Coverage Options

Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family members through the Health Insurance Marketplace (ACA Exchange), Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as coverage under your spouse's plan) through a special enrollment period. Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare instead of COBRA Coverage. In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Qualifying Events for COBRA Coverage

Employee. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

- Your hours of employment are reduced; or,
- Your employment ends for any reason other than your gross misconduct.

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA Coverage.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- The employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Dependent Children. Your dependent children will become qualified beneficiaries if they lose coverage under

the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Notifying the Plan of a Qualifying Event

The Plan will offer COBRA Coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. However, when the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA Coverage to qualified beneficiaries without notification that such a qualifying event has occurred.

You Must Notify the Plan Administrator of Certain Qualifying Events. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the School in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to:

Denver Public Schools
Attn: Benefits Administrator
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864

You may lose your right to elect COBRA Coverage if proper procedures are not followed within the time periods described.

COBRA Coverage Elections

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries who then will have an independent right to elect coverage. Covered employees may elect COBRA Coverage on behalf of their spouses, and parents may elect COBRA Coverage on behalf of their children.

If mailed, your election must be postmarked (or if hand delivered, your election must be received by the individual at the address specified on the election form) no later than 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event (or, if later, 60 days after the date that Plan coverage is lost).

Please Note: If, at the time of the qualifying event, you were covered under benefits that are not protected by COBRA (e.g. life insurance, AD&D, disability), you may, depending on applicable state law, be able to convert such benefits to an individual policy. If a conversion option is available in your state, you will be required to make the necessary arrangements directly with the applicable insurance Issuer.

Length of COBRA Coverage

The COBRA Coverage periods described below are maximum coverage periods. COBRA Coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Early Termination of COBRA Coverage" section below.

Employee Coverage. Under COBRA, employees themselves are only eligible for either:

- 18 months of coverage, due to termination of employment or a reduction in hours; or,
- 29 months of coverage, if a qualified beneficiary covered under the Plan is eligible for a disability extension (which occurs when the individual is determined to be disabled by the Social Security Administration before the 60th day of COBRA Coverage and remains disabled for the initial 18 months of coverage). The 11-month extension begins at the conclusion of the original 18 months of coverage.

COBRA Coverage will be available to the employee and any covered family members. Additionally, under USERRA, covered employees who enlist in the military or are called to active duty may have COBRA-like coverage rights for themselves and their dependents that last for up to 24 months.

Dependent/Qualified Beneficiary Coverage. Dependents who are qualified beneficiaries are eligible for the same coverage durations above, but their coverage may extend even further in certain situations:

- 36 months of coverage, due to losing dependent-child status under the plan;
- Up to 36 months of coverage, when the qualifying event is the employee's termination of employment or a reduction in hours and the employee became entitled to Medicare less than 18 months before the qualifying event (where the 36 months is measured from the date the employee became entitled to Medicare); or,
- Up to 36 months of coverage, when there is a second qualifying event during continuation coverage (the death of the covered employee; the divorce or separation of the employee and spouse; the covered employee becoming entitled to Medicare or loss of dependent-child status under the Plan), where the 36 months is measured from the original COBRA Coverage start date.

  These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

Notification Requirement for Extensions. The extension of COBRA Coverage due to a disability or another second qualifying event is available only if you notify the School in writing within 60 days after the qualifying event. You must provide this notice to:

Denver Public Schools
Attn: Benefits Administrator
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864

For the disability extension, the notice must be provided within 60 days of the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, to be entitled to a disability extension, you must provide the notice within 18 months after the covered employee's termination of employment or reduction of hours.

You may lose your right to elect COBRA Coverage if proper procedures are not followed within the time periods described.

Special COBRA Rule for Health FSAs. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year. Health FSA COBRA coverage will only last until the end of the Plan Year during which the qualifying event occurred. **The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount, if applicable) will be forfeited at the end of the Plan Year (and grace period if applicable) and the Health FSA COBRA coverage will be terminated**.

If applicable, any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse health care expenses until the qualified beneficiary's other COBRA coverage (e.g. medical, dental, vision) ends.

Conversion Rights for Fully-Insured Medical Coverage. At the end of the 18, 29, or 36-month continuation period, you may be eligible to convert your fully-insured medical coverage to an individual policy. If you are eligible, you will be required to make the necessary arrangements directly with the applicable insurance Issuer.

Early Termination of COBRA Coverage

COBRA Coverage will automatically terminate before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. Note that he or she must notify the School in writing within 30 days after a qualified beneficiary becomes entitled to Medicare benefits or becomes covered under other group health plan coverage;
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. Note that you must notify the School in writing within 30

days after the Social Security Administration determines that a qualified beneficiary is no longer disabled;

- The School ceases to provide any COBRA-eligible group health plan coverage for its employees; or,
- For any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA Coverage (such as for fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA Coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA Coverage due to a disability, 150%) of the cost to the group health plan ("Applicable Premium") (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA Coverage.

For self-insured group health benefits, the amount the Plan may charge for COBRA Coverage will depend on the amount of Applicable Premium for such coverage. Applicable Premium may be equal to either:

- A reasonable estimate of the cost of providing coverage determined on an actuarial basis; or,
- The cost of coverage for the immediately preceding Plan Year (including claims costs, administrative expenses, stop-loss premiums, and stop-loss reimbursements) as adjusted for cost of living.

The amount of your COBRA premiums may change from time to time during your period of COBRA Coverage and will most likely increase over time. You will be notified of any COBRA premium changes.

Payment for COBRA Coverage. If you elect continuation coverage, you do not have to send any payment with the COBRA election form. However, you must make your first payment for COBRA Coverage no later than 45 days after the date of your election (this is the date the envelope containing the payment is post-marked, if mailed). **If you do not make your first payment for COBRA Coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan**. You are responsible for making sure that the amount of your first payment is correct and paid in a timely manner.

After you make your first payment for COBRA Coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for COBRA Coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. **The Plan will not send periodic notices of payments due for these coverage periods, so it's important to keep track of the due dates**.

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA Coverage will continue for each coverage period if payment for that period is made before the end of the grace period for that payment.

Plan Contact Information

In order to protect your and your dependent's rights, you should keep the School informed of any changes in your address and the addresses of family members.

Denver Public Schools Employee Benefit Plan
Denver Public Schools
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864

ADDITIONAL HEALTH PLAN PROVISIONS

The following additional health plan provisions apply to Component Plans that are group health plans. Note that the definition of the health plans subject to each law may vary. If you have any questions about which law or laws apply to your benefits, contact the Plan Administrator.

Temporary Provisions Related to COVID-19

The following federal provisions were enacted in response to the 2019 Coronavirus ("COVID-19") National Emergency. These provisions shall sunset on the dates specified below, or as specified in any further COVID-19 legislation or regulatory guidance.

Deadline Extensions for Participant Actions

In accordance with federal guidance, the Plan Administrator shall disregard the period from March 1, 2020 until 60 days after the announced end of the COVID-19 National Emergency or such other date announced by the Agencies in any future notice ("Outbreak Period") when determining the deadline for any of the following participant actions:

Special Enrollment: The 30-day period (or 60-day period, if applicable) to request HIPAA special enrollment.

COBRA Continuation Coverage:

- The 60-day election period for COBRA continuation coverage after receipt of the COBRA Election Notice;
- The date for making COBRA premium payments (e.g. 45-day initial payment deadline and/or 30 day grace period for subsequent payments); and,
- The 60-day period for individuals to notify the plan of a COBRA qualifying event (e.g. divorce/legal separation, child attaining age 26, or SSA disability determination).

Claims/Appeals:

- The deadline to file a claim under the Plan's claims procedures;
- The deadline to file a claim for a Health FSA during a runout period if the runout period ends any time during the Outbreak Period;
- The deadline to file an appeal of an adverse benefit determination; and,
- The deadline to file, if applicable, a request for external review of a final adverse benefit determination or, if a request for external review was not complete, to file information to perfect the request for an external review.

The above provisions shall be administered in accordance with Families First Coronavirus Response Act ("FFCRA"), the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") and any applicable guidance related to the COVID-19 National Emergency.

Expansion of Eligible OTC Medical Expenses

For expenses incurred after December 31, 2019, the Coronavirus Aid, Relief, and Economic Security Act ("the CARES Act") expands IRS regulations to allow Health FSAs, Health Savings Accounts ("HSA"), and other account-based group health plans to pay for or reimburse expenses for menstrual care products and certain over-the-counter ("OTC") medicines and drugs *without a prescription*.

Title VII of the Civil Rights Act of 1964

Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act")

Group health plans and health insurance Issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours

as applicable). In any case, plans and Issuers may not, under Federal law, require that a provider obtain authorization from the plan or the Issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, in order to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to provide the Plan with advance notice of services or providers related to the hospital stay. For information on precertification, contact your Plan Administrator.

Women's Health and Cancer Rights Act

In the case of an employee or dependent who receives benefits under the medical plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which a mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan.

Affordable Care Act

Certain group health plans have become subject to provisions of the ACA. Notwithstanding anything in the Plan to the contrary, the Plan shall comply with the ACA and all applicable regulations, as may be amended from time to time. Nothing in this section is intended to expand your rights beyond ACA's requirements or the requirements of any other applicable federal or state law.

Patient Protections

Primary Care Provider Designation. If a non-grandfathered group health plan requires or allows participants to designate primary care providers, or if the Plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the Plan's network and who is available to accept the participant or participant's family members.

Access to Pediatric Care. If a non-grandfathered group health plan requires or provides for the designation of a participating primary care provider for a dependent child, the Plan shall permit such person to designate a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties) as the child's primary care provider if such provider participates in the network of the Plan or Issuer.

Access to Obstetrical or Gynecological Care. A participant, regardless of age, shall not need prior authorization from a non-grandfathered group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

Emergency Services. A non-grandfathered group health plan that provides emergency services may not require preauthorization for those services. Emergency services must be provided regardless of whether the provider is in- or out-of-network without any time limit within which treatment must be sought.

In addition, the plan generally cannot impose any copayment or coinsurance for out-of-network emergency services that is greater than what would be imposed if the services were provided in-network.

Mandated Coverage

Preventive Care Services. Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for certain recommended preventive services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex assigned at birth, gender identity, or gender of the individual, as recorded by the plan. Updated lists of the preventive services covered under this provision are available at https://www.healthcare.gov/coverage/preventive-care-benefits/.

Coverage for Clinical Trials. Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees, and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an ap-

proved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. If a participant experiences complications as a result of the clinical trial, any treatment of those complications must be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

Mental Health Parity and Addiction Equity

All group health plans that provide both medical and surgical benefits, as well as mental health or substance use disorder benefits, shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and,
- The Plan Administrator or Issuer must make available to participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services.

Under the ACA, group health plans are prohibited from imposing annual or lifetime dollar limits on Essential Health Benefits, including mental health and substance use disorder services and behavioral health treatment.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 ("GINA") requires group health plans to not discriminate based on genetic information with respect to eligibility, premiums, and contributions. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not identify the individual. When GINA applies, genetic information is treated as Protected Health Information ("PHI") under HIPAA.

"Genetic information" includes any information about an individual's own genetic tests, the genetic tests of an individual's family members, and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes (essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition).

Wellness Program

The School may offer one or more voluntary wellness programs or disease management programs (each a "Program") under this Plan that are reasonably designed to promote the health and wellbeing of covered individuals. Such Programs offer certain incentives or rewards for participation in a Program or for satisfying certain health standards. If the School chooses to offer a Program or Programs, its terms and conditions will be communicated to you and it will be administered in compliance with all applicable laws.

Any requests for a reasonable alternative standard (described below) or to obtain more information, including a copy of the Program's Privacy Notice should be directed to the School's Benefits Administrator at 720-423-3864.

Notice of Reasonable Alternative Standard. In the event a Program requires individuals to satisfy a standard related to a health factor that is "activity-only," and it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under a Program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward, the Plan will work with you (and if you wish, with your physician) to develop another way to qualify for the reward.

If a Program requires individuals to satisfy a standard related to a health factor that is "outcome-based," you may request a reasonable alternative standard regardless of whether it is unreasonably difficult due to a medical condition or medically inadvisable to attempt to satisfy the standard.

Notice of Privacy and Non-Discrimination Rights. The School is required to maintain the privacy and security

of your personally identifiable health information, including any disability-related information collected through your participation in a Program.

In addition, you may not be discriminated against in employment because of the medical information you provide as part of participating in a Program, nor may you be subjected to retaliation if choose not to participate in a Program.

CLAIMS AND APPEAL PROCEDURES

The following claims and appeal procedures must be followed by Plan participants ("Claimants") to obtain payment of benefits under the Plan, but only to the extent not otherwise provided in the applicable Component Plan's Benefit Documents. If the claims and appeal procedures in this section apply, they shall be construed and applied in a manner consistent with the ACA and the Department of Labor ("DOL") Regulation Section 2560.503-1 as in effect on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

For purposes of this Section, the term "Administrator" means the group insurance policy Issuer or self-insured plan contract administrator listed on Appendix A for the policy or plan under which the claim has been filed.

Claims Procedures under Component Plans

The Benefit Documents provided by the Administrator for each Component Plan generally contain a detailed description of the Administrator's claims submission rules, claims and appeal procedures, and the member services contact information for any claims questions. Please refer to Appendix B for a listing of claims and claims appeal contacts, addresses, and phone numbers.

The Administrator will act as, or will designate, a claims administrator to decide your claim in accordance with its reasonable claims procedures, as required by applicable law. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

If the Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial ("Adverse Determination"). You may request a review of a denied claim by appealing to the Administrator. The Administrator will decide your appeal in accordance with its reasonable claims and appeal procedures, as required by applicable law. In addition, certain group health plans must provide for external review procedures upon the exhaustion of your internal appeal process (e.g. review of your claim outside of the Plan).

Unless specifically provided otherwise in a Component Plan, you must make a claim for benefits under the Plan and any Component Plan within one year after the date you incurred the expense that gives rise to the claim. It is your responsibility to make sure this requirement is met.

Reasonable claims and appeal procedures may not preclude an authorized representative from acting on your behalf in pursuing or appealing a benefit claim. You are responsible for providing the Administrator, claims administrator and/or the School with your current address. The Plan Administrator, claims administrator and the School do not have any obligation or duty to locate a person who is or may become entitled to benefits under the Plan except as required by applicable law.

Types of Claims

A claim is a request for benefits made in accordance with a Component Plan's claims-filing procedures, including any request for a service that must be pre-approved. Questions concerning Plan benefits, coverage and eligibility questions, and other casual inquiries are generally not considered claims for benefits.

Group Health Claims

For purposes of group health plans (e.g. medical, dental, vision), there are four types of health claims: Urgent Care, Pre-Service, Post-Service, and Concurrent Care ("Health Claims").

- Urgent Care Claim**.** An "Urgent Care Claim" is a claim (other than a post-service claim) for which the application of a non-urgent care timeframe could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Component Plan must defer to an attending provider to determine if a claim for health benefits is urgent.
- Pre-Service Claim. A "Pre-Service Claim" is a non-urgent claim for a benefit under the Component Plan where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- Post-Service Claim. A "Post-Service Claim" is a claim for a benefit under the Component Plan after the services have been rendered.
- Concurrent Care Claim**.** A "Concurrent Care Claim" is a claim for which the Component Plan previously

has approved a course of treatment over a period of time or for a specific number of treatments, and either the plan later reduces or terminates coverage for those treatments, or you request to extend coverage for those treatments. A concurrent care claim may be treated as an Urgent Care Claim, Pre-Service Claim, or Post-Service Claim, depending on when during the course of your care you file the claim.

Disability Claims

A "Disability Claim" is a claim for benefits that requires you to prove a disability with respect to which the Component Plan makes its own determination of whether you are disabled, regardless of the type of plan under which the claim arises. However, if someone other than the Component Plan makes the determination of disability, for purposes other than the Component Plan's benefit determination (e.g., the Social Security Administration or a different benefit plan), the claim is not a Disability Claim.

Other Non-Health Claims

The term, "Other Non-Health Claims," encompasses claims that are neither Health Claims nor Disability Claims. Examples include, but are not limited to, claims for benefits under Component Plans that are severance plans, life insurance plans, accidental death and dismemberment plans, business travel insurance plans, and long-term care plans.

Submission of Claims

Each Component Plan shall place conditions on how and when a claim must be made, as well as require submission of specific information with claims, including medical information and coordination of benefits information. Each Component Plan's claims procedures shall contain a formalized system of administrative safeguards to ensure that claims are decided consistently with Plan documents and with past determinations in similar circumstances.

Special Notice for Incorrectly Filed Urgent Care or Pre-Service Claims. In the case of an incorrectly filed Urgent Care Claim or Pre-Service Claim, the Administrator will notify you as soon as possible but no later than 24 hours (Urgent Care) or five days (Pre-Service) following receipt by the Component Plan of the incorrectly filed claim. The notice may be written or oral unless you request a written notice and must include information regarding proper procedures to follow.

Notice of the Claim Determination

The Administrator must provide you with a notice of an Urgent Care or Pre-Service determination (whether adverse or not). If the Administrator decides in favor of the claim, the notice will include sufficient information to fully apprise you of the Component Plan's decision to approve the requested benefits.

For all initial claims, if the claims administrator of the Component Plan does not fully agree with your claim, you shall receive an adverse benefit determination ("Adverse Determination"), which is a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An Adverse Determination for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim submitted on or after April 1, 2018, may include a claim for benefits due to a rescission of coverage (generally a retroactive cancellation of coverage).

Timing of Initial Adverse Determinations

The time period for an initial Adverse Determination begins running when a claim is filed, even if the claim is incomplete. The original determination period for deciding certain claims (but generally not appeals) may be extended by the Administrator. However, there can be no extension unless an extension notice is provided to you *prior* to the end of the original determination period. The extension notice must indicate the matters beyond the control of the Component Plan that gave rise to the need for the extension and the date by which a determination is expected to be made.

The Administrator shall provide you with the Adverse Determination within the following timeframes:

Group Health Plan Claims:

- **Urgent Care Claim**: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Component Plan if all information was included with the claim. If the Urgent Care Claim is incomplete, the Administrator will notify you within 24 hours and you will have a reasonable period of time, but no less than 48 hours to complete the claim. The Administrator will then decide the claim as soon as possible but no later than 48 hours after the earlier of the receipt of the specified information, or the end of the period of time provided to submit the specified information.
- **Non-Urgent Pre-Service Claim**: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the

claim by the Component Plan. The Administrator may extend the original period for up to 15 days upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.

- **Post-Service Claim**. Within a reasonable time, but no later than 30 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for up to 15 days upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.
- **Concurrent Care Claim Related to Termination or Reduction of Treatment**. Within enough advance time to provide the Claimant with an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.
- **Concurrent Care Claim Related to Request for Extension of Treatment**. In the case of an Urgent Care Claim, within 24 hours after receipt of the claim by the Component Plan provided your request is made at least 24 hours prior to the end of the approved treatment. All other non-urgent claims will be treated as a new Non-Urgent Pre-Service or Post-Service Claim as applicable.

Disability Claims. Within a reasonable period of time, but not later than 45 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for two additional 30-day extension periods upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.

Other Non-Health Claims. Within a reasonable period of time, but not later than 90 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for an additional 90 days upon written notice to you.

Content of the Adverse Determination Notice

The Administrator must provide you with a written or electronic "Notice of Adverse Determination," except that the notice for an Urgent Care Claim may be provided orally (within the applicable timelines) so long as a written or electronic notice is provided to you within three days.

The Notice of Adverse Determination must be written in a manner calculated to be understood by you. In addition, the Notice for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim must be provided to you in a culturally and linguistically appropriate manner.

The Notice of Adverse Determination shall include the following information:

- The specific reason for the Adverse Determination;
- References to the specific Component Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Component Plan's review procedures and the applicable time limits; and,

The Notice of Adverse Determination for a Health Claim, or a Disability Claim submitted on or after April 1, 2018, will include the following information:

- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to you by including a statement that the information is available free of charge upon your request. If applicable, the notice for Disability Benefits must include an explanation of why such internal guidelines or criteria do not exist.
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the determination, or a statement that such explanation will be provided free of charge upon your request; and,
- In the case of a Health Claim involving Urgent Care, a description of the expedited review process applicable to such claim.

The Notice of Adverse Determination for a Health Claim related to a non-grandfathered group health plan will include the following additional information:

- Information sufficient to identify the claim involved;
- A description of the Component Plan's standard, if any, used in denying the claim;
- A description of available internal appeals and external review procedures; and,
- Disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who can assist individuals with their claims.

The Notice of Adverse Determination for a Disability Claim submitted on or after April 1, 2018 will include the following additional information:

- A discussion of the decision, including the reasons for disagreeing with the views of treating professionals, medical or vocational experts consulted, or a disability determination made by the Social Security Administration; and,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

Appealing a Denied Claim

If you disagree with an Adverse Determination after following the above steps, you or your appointed representative may formally request an appeal by following the Component Plan's appeal procedures as set forth in the Component Plan's Benefit Documents.

In the appeal, you may submit written comments, documents, records, and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. In addition, for a Health Claim related to a non-grandfathered group health plan, you must be permitted to present evidence and testimony as part of the appeal process.

You may appeal any denial of a Health Claim or Disability Claim within 180 days (within 60 days for Other Non-Health Claims) of receipt of such a denial by submitting a written request for review to the Administrator. If you do not appeal in a timely manner, you lose your right to later object to an adverse determination on review ("Appeal Decision").

If the appeal relates to a claim for payment, your request should include, at minimum:

- The patient's name and the identification number from the ID card,
- The date(s) of service(s),
- The provider's name,
- The reason you believe the claim should be paid, and,
- Any documentation or other written information to support your request for claim payment.

Full and Fair Review

The review of your claim shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial Adverse Determination. The Component Plan will identify, upon request to the Administrator, any medical experts or vocational experts whose advice was obtained on behalf of the Component Plan in connection with your Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination.

The review of your appeal shall be conducted by an appropriate fiduciary of the Component Plan who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.

In the case of a Health Claim involving urgent care, you are entitled to an expedited review process pursuant to which you may submit a request for an expedited Appeal Decision orally or in writing and all necessary information shall be transmitted between you and the Component Plan by telephone, facsimile, or other available similarly expeditious method.

In deciding an appeal for a claim that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.

The Component Plan must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Component Plan (or at the direction of the Component Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notification of Appeal Decision is required to be provided to give you a reasonable opportunity to respond prior to that date. In addition, before the Administrator can issue an Appeal Decision based on new or additional rationale for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim submitted on or after April 1, 2018, you must be provided, free of charge, with the rationale, which must be provided to you as soon as possible and sufficiently in advance of the date on which the Appeal Decision is required to be provided to give

you a reasonable opportunity to respond prior to that date.

Appeal Decision

If your claim on appeal is wholly or partially denied, the Administrator will provide you with a written notification of the Component Plan's Appeal Decision, within the required timeframes. In addition, the notice of the Appeal Decision for a Disability Claim, or a Health Claim related to non-grandfathered group health plan, must be provided in a culturally and linguistically appropriate manner.

Any determination by the Administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously.

Timing of the Appeal Decision

For purposes of this section, the period of time within which the Appeal Decision is required to be made shall begin at the time your appeal is filed in accordance with the Component Plan's procedures without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

Group Health Plan Claim. The Administrator shall provide you with the Appeal Decision within the following timeframes:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Component Plan.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Component Plan.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Component Plan**.**
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the Adverse Determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of claim.

Disability Claim. The Administrator shall provide you with the Appeals Decision within 45 days after receipt of the appeal by the Component Plan.

All Other Non-Health Claim. The Administrator shall provide you with the Appeal Decision within 60 days after receipt of the appeal by the Component Plan.

Content of the Notice of Appeal Decision

The Administrator must provide you with a written or electronic notice of an Appeal Decision. The Notice of Appeal Decision must be written in a manner calculated to be understood by you. In addition, the Notice for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim, must be provided to you in a culturally and linguistically appropriate manner. The Notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Component Plan provisions on which the Appeal Decision is based;
- A statement regarding your right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Component Plan and your right to obtain information about such procedures; and,

For an Appeal Decision related to a Health Claim, or a Disability Claim filed on or after April 1, 2018, the notice will include:

- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to you by including a statement that the information is available free of charge upon your request. If applicable, the notice for Disability Benefits must include an explanation of why such internal guidelines or criteria do not exist; and,
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the determination, or a statement that such explanation will be provided free of charge upon request.

The Notice of Appeals Decision for a Health Claim related to a non-grandfathered group health plan will include the following additional information:

- Information sufficient to identify the claim involved;
- A description of the Component Plan's standard, if any, used in in the Appeal Decision;

- A description of available internal appeals and external review procedures; and,
- Disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who can assist individuals with their claims.

The Notice of Appeal Decision for a Disability Claim submitted on or after April 1, 2018 will include the following additional information:

- A statement describing any applicable plan-imposed limitations period, including the calendar date when the limitations period will expire; and,
- A discussion of the decision, including the reasons for disagreeing with the views of treating professionals, medical or vocational experts consulted, or a disability determination made by the Social Security Administration.

Second Appeal

If specified in the Benefit Documents for each Component Plan or in documentation given to you by the claims administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

If a second appeal is provided by a Component Plan that is not a group health plan, the notification of the Appeal Decision with respect to the second appeal will be made in accordance with the same guidelines as those outlined above for the first appeal. If a second appeal is provided by a Component Plan that is a group health plan, the Appeal Decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim**. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim**. The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

Failure to Follow Claims Procedures

Generally, you are required to complete or exhaust a Component Plan's claims and appeal procedures as a prerequisite to filing a lawsuit for benefits. If your claim is related to a Component Plan that is a non-grandfathered group health plan or a plan that provides disability benefits, and the Component Plan fails to establish or follow a procedure that is consistent with the federal regulations, the Claimant will be deemed to have exhausted administrative remedies and the Claimant then may seek an external review (if applicable).

However, this will not apply if the error was de minimis, if the error does not cause harm to you, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. You may request a written explanation of the violation from the Component Plan, and the Component Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Component Plan to be deemed exhausted.

Group Health Plan External Review

If your internal appeal for a benefit provided by a Component Plan that is a non-grandfathered group health plan is denied, you may have the right to have the claim reviewed by an independent reviewer organization (IRO), not employed by the Component Plan, through an external review process. This applies to claims that involve medical judgment as determined by the external reviewer or a rescission of coverage. You will be allowed at least four months to file a request for external review after the receipt of the Adverse Determination or Appeal Decision. The external review decision is binding on you and the Component Plan, except to the extent other remedies are available under federal law.

Exhausting Administrative Remedies and Filing Suit

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. **If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this EPS or, if applicable, the Benefit Documents of a Component Plan, you may lose the right to file suit in state or federal court.**

A lawsuit seeking benefits under this Plan must be brought within certain time limits as detailed in the "Legal Actions" section of this EPS and in accordance with all applicable laws.

PLAN ADMINISTRATION

In General

The School is the "Plan Administrator" of the Plan and a "Named Fiduciary." In addition, the School is the Plan's agent for service of legal process.

The School has the duty and discretionary authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each employee shall, from time to time, upon request of the School, furnish to the School such data and information as the School shall require in the performance of its duties under the Plan.

The School may designate any individual, partnership, or other organization to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

The School may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan.

The School will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Refund of Premium

For purposes of fully-insured Component Plans, where any refund of premium (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) is determined to be plan assets attributable to participant contributions, such assets will be:

- Distributed to current Plan participants within 90 days of receipt;
- Used to reduce participants' portion of future premiums under the Plan; or,
- Used to enhance future benefits under the Plan.

Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Privacy and Security of Information

Certain Component Plans provided under this Plan are health plans subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including regulations affecting the maintenance, creation or use of Protected Health Information ("PHI") (as defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

Plan Amendment and Termination

The School reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time, in its sole discretion, except as otherwise specified in a collective bargaining agreement. For example, the School reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. The School also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by the School will be done in accordance with the School's normal operating procedures.

OTHER IMPORTANT INFORMATION

Legal Actions

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of Colorado.

The time limit for bringing any lawsuit that arises under or relates to this Plan or a Component Plan is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, you must complete the applicable claims procedure set out in the Plan or the Component Plan, as applicable (and comply with all applicable deadlines). If you fail to properly exhaust the claims procedure, you will lose your right to file a lawsuit with respect to the claim.
- In the case of a Component Plan that is self-insured by the School, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; and claims against nonfiduciaries) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the insurance company or the Plan will be determined by the terms of the applicable Component Plan. If the Component Plan does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

Right of Reimbursement from Third Parties

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. Accordingly, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount, or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Non-Assignment of Benefits

Except as otherwise specifically provided in the Plan or required by law, benefits payable for you or your dependents under the Plan may not be assigned, transferred or in any way made over to another party. Additionally, to the extent any assignment of benefits is permitted under any Component Plan, the Plan Administrator or the responsible fiduciary reserves the discretionary authority to determine whether any purported assignment of Plan benefits to a provider is valid. As such, the Plan does not guarantee that any purported assignment will be valid under the terms of the Plan or any insurance contract.

Controlling Documents

The information contained in this EPS is a general discussion of the relevant provisions of the Plan found in the official Plan document and Component Plan Benefit Documents. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan.

APPENDIX A

DENVER PUBLIC SCHOOLS EMPLOYEE BENEFIT PLAN

EMPLOYEE PLAN SUMMARY

Insurance Policy Issuers and Contract Administrators of Component Plans

See the Summary of Plan Changes (SPC) attached to this EPS for an updated list of the Plan's incorporated Component Plans.

APPENDIX B

DENVER PUBLIC SCHOOLS EMPLOYEE BENEFIT PLAN
EMPLOYEE PLAN SUMMARY

Claims Administrator Contact Information

Use the address and phone number provided on your ID Card if different.

See the Summary of Plan Changes (SPC) attached to this EPS for updated claims administrator contact information.

APPENDIX C

DENVER PUBLIC SCHOOLS EMPLOYEE BENEFIT PLAN

EMPLOYEE PLAN SUMMARY

Eligibility and Participation Requirements

Employee Eligibility

An employee who is determined to be benefit-eligible as of his or her start date shall be offered coverage as of the Effective Date of Eligibility specified below.

Employee Class	Working Hours Requirement	Benefits Offered	Effective Date of Eligibility
Full-Time Employees	30 hours per week	All benefits listed on Appendix A	First day of the month following date of hire
Part-Time Hourly Employees working at least 20 hours per week	20 hours per week	All benefits listed on Appendix A except AD&D and LTD	First day of the month following date of hire
Part-Time Hourly Employees working less than 20 hours per week	Less than 20 hours per week	EAP, MetLife home, auto, and pet insurance, commuter benefits	First day of the month following date of hire

Certain Component Plans may delay the effective date of your eligibility if you are not "actively-at-work" (e.g. at work performing all of the regular duties of your job). Any actively-at-work requirement imposed by a group health plan (as defined by HIPAA) will not apply if the reason you are not actively-at-work is due to a health condition.

Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees. If, based on the facts and circumstances on the start date of a new employee, the School determines that such employee is not reasonably expected to be employed an average of at least 30 hours of service per week (or 130 hours of service per month) or is a seasonal employee, then the School shall determine the employee's eligibility or ineligibility for certain Component Plans (e.g. medical benefits) based on separate rules described in the "Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees" Section below.

Dependent Eligibility

Unless specified otherwise under the applicable Component Plan's Benefit Documents, coverage for dependents, if elected, begins on the date your coverage begins (provided you timely enroll them in coverage). If your family grows as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependent(s) mid-Plan Year provided you enroll them in a timely manner after your corresponding Qualifying Life Event.

Dependent Definitions. For purposes of eligibility and participation in this Plan, dependent definitions shall have the same meaning set forth in each applicable Component Plan's Benefit Documents which are incorporated by reference herein. Unless otherwise defined in the Benefit Documents for a Component Plan, your eligible dependents include:

- Your lawful spouse under applicable law (including your common-law spouse), unless legally separated by court decree.

- Your child(ren) under age 26 (regardless of financial dependency, residency with you, marital status, or student status), or if older, your unmarried child who is principally supported by you and who you can certify (on a periodic basis) is not capable of self-support due to a physical or mental disability that either began while the child was covered under the Plan or occurred prior to attaining age 26. For purposes of the Plan, a child includes:
    - Your (or your spouse's) natural child, stepchild, legally adopted child (including any child lawfully placed for adoption with you by a court of competent jurisdiction);
    - A foster child who has been placed with you by an authorized placement agency or by judgment, decree, or other court order of any court of competent jurisdiction;
    - A child for whom you have court-appointed legal guardianship that legally resides with you in a parent-child relationship and is chiefly dependent on you for support and maintenance.
- An eligible child for whom you are required to provide coverage under the terms of a National Medical Support Notice issued through an administrative process that has the force and effect of law under applicable state law.

Proof of Dependent Status. The School reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by the School shall be final, binding and conclusive on all parties claiming an interest in the Plan.

Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Component Plan's Benefit Documents, in no event will an employee be covered under a Component Plan as both a participant and a dependent, or a dependent be covered under a Component Plan as a dependent of more than one participant.

Rehire Rule

An employee who is rehired prior to the end of a certain period of time after date of termination may be credited with hours of service met towards the eligibility waiting period during his or her preceding period of employment. If applicable, the Benefit Documents for each Component Plan will set forth the specifics for such rehire rules. Otherwise, a terminated employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and participation requirements for his or her employment class.

Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACA-FT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event the School adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by the School (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from the School's Benefits Administrator.

Summary of Plan Changes

To: **Participants**

From: **Denver Public Schools**
Benefits Administrator

Re: **Amendment to the Denver Public Schools Employee Benefit Plan**
Benefit Plan and Mandatory Legislative Updates

Effective Date: July 1, 2022

This Summary of Plan Changes (SPC) describes changes to the Denver Public Schools Employee Benefit Plan (Plan) and supplements or modifies the information presented in your Employee Plan Summary (EPS) with respect to the Plan. You should keep this SPC with the Plan's EPS and associated benefits documents provided to you upon enrollment in each benefit plan.

Summary of Plan Changes

1. **Plan Contact Information Update**. As of the Effective Date, the contact for your questions related to the Plan has been updated to the following:

   Denver Public Schools
   Attn: Benefits Administrator
   1860 Lincoln Street, 11th Floor
   Denver, CO 80203
   720-423-3864
   derek_bell@dpsk12.org

2. **Benefit Plan Changes.** Denver Public Schools ("DPS") hereby amends the Plan to modify the Plan's appointed group insurance policy issuers and contract administrators as follows:

   - DPS appoints MotivHealth as the new administrator of the Plan's new self-insured Medical HDHP plan (with HSA).
   - DPS terminates the Unum Voluntary Long-Term Care policy with no replacement benefit.

   As of the Effective Date, the attached Appendix A ("Insurance Policy Issuers and Contract Administrators of Component Plans") and Appendix B ("Claims Administrator Contact Information") (**Attachment 1**) lists the Plan's appointed insurance policy issuers/contract administrators and claims administrators and shall supersede all prior versions of the same Appendices A and B to your EPS.

3. **Expansion of the ACA's Patient Protections.** The Consolidated Appropriations Act of 2021 ("CAA") expands upon the original ACA patient protection rules.

   a. Effective as of January 1, 2022, the "Patient Protections" provisions under the "Affordable Care Act" section of the EPS's "ADDITIONAL HEALTH PLAN PROVISIONS" section shall be replaced in its entirety with the following:

      Patient Protections
      Designation of Primary Care Provider and Pediatrician. If **a** group health plan requires or allows a participant to designate a primary care provider (including for dependent child(ren)), or if the plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the group health plan's network and who is available to accept the participant or participant's family members. For dependent children this means a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties).

      Direct Access to Obstetrical and Gynecological Care. A participant, regardless of age, shall not need prior authorization from a group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

b. Effective as of January 1, 2022, the following new section ("Emergency Services and Surprise Medical Billing Protections") is hereby added to the EPS's "ADDITIONAL HEALTH PLAN PROVISIONS" section:

Emergency Services and Surprise Medical Billing Protections

Emergency Services. A group health plan that covers emergency services generally must provide such services regardless of whether the provider is in- or out-of-network and without requiring prior authorization. The group health plan generally cannot impose any cost-sharing requirement (i.e., copayment, coinsurance, deductible) greater than (or an administrative requirement/limitation more restrictive than) what would be imposed if the services were provided in-network.

Nonemergency Services. A group health plan that covers out-of-network nonemergency services performed in an in-network facility generally must cover such services without any cost-sharing requirement that is greater than would apply if provided in-network. However, the out-of-network provider is not prohibited from balance billing certain services so long as the participant receives prior notice and consents to the treatment.

Any cost-sharing payments made by a participant for the above out-of-network emergency or nonemergency services must count towards the group health plan's in-network deductible (if applicable) and out-of-pocket maximum.

Continuity of Care. When a group health plan provider ceases to be an in-network provider during a continuing care patient's ongoing course of treatment (as specified under the CAA) the plan generally must provide timely notice to the participant and potentially provide transitional care under the same terms and conditions as would have applied had no change occurred.

All other Plan provisions remain unchanged so long as they are consistent with these Summary of Plan Changes. For additional information regarding the Plan or to request a copy of the Plan's EPS contact:

Denver Public Schools
Attn: Benefits Administrator
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864 or derek_bell@dpsk12.org

Plan Information:

Plan Name: Denver Public Schools Employee Benefit Plan
Plan Year: July 1 through June 30 of the following calendar year

Summary of Plan Changes

To: **Participants**

From: **Denver Public Schools**
Benefits Administrator

Re: **Amendment to the Denver Public Schools Employee Benefit Plan**
Benefit Plan Changes

Effective Date: July 1, 2023

This Summary of Plan Changes (SPC) describes changes to the Denver Public Schools Employee Benefit Plan (Plan) and supplements or modifies the information presented in your Employee Plan Summary (EPS) with respect to the Plan. You should keep this SPC with the Plan's EPS and associated benefits documents provided to you upon enrollment in each benefit plan.

Summary of Plan Changes

1. **Benefit Plan Changes.** Denver Public Schools ("DPS") hereby amends the Plan to modify the Plan's appointed contract administrators as follows:

   - DPS appoints United Healthcare as the new administrator of the Plan's self-insured Medical – CDHP and Medical – Deduction HMO plans.

   As of the Effective Date, the attached Appendix A ("Insurance Policy Issuers and Contract Administrators of Component Plans") and Appendix B ("Claims Administrator Contact Information") (**Attachment 1**) lists the Plan's appointed insurance policy issuers/contract administrators and claims administrators and shall supersede all prior versions of the same Appendices A and B to your EPS.

All other Plan provisions remain unchanged so long as they are consistent with these Summary of Plan Changes.

For additional information regarding the Plan or to request a copy of the Plan's EPS contact:

Denver Public Schools
Attn: Benefits Administrator
1860 Lincoln Street, 11th Floor
Denver, CO 80203
720-423-3864 or derek_bell@dpsk12.org

Plan Information:

Plan Name: Denver Public Schools Employee Benefit Plan
Plan Year: July 1 through June 30 of the following calendar year

APPENDIX A

DENVER PUBLIC SCHOOLS EMPLOYEE BENEFIT PLAN

EMPLOYEE PLAN SUMMARY

Insurance Policy Issuers and Contract Administrators of Component Plans

This Appendix A reflects the Plan benefits as of July 1, 2023. The Benefit Documents for the following Component Plans are incorporated by reference herein. All subsequent updates to such Benefit Documents will supersede any earlier versions for the periods defined in the updated materials.

Fully-Insured Component Plans	Policy/Group No.	Type of Benefit
ComPsych 455 North Cityfront Plaza Drive, 13th Floor Chicago, IL 60611-5322	—	Employee Assistance Program (EAP)
MetLaw 1111 Superior Avenue, Suite 800 Cleveland, OH 44114	—	Prepaid Legal
Metropolitan Life Insurance Company (MetLife) 200 Park Avenue New York, NY 10166	16430	Basic Life/AD&D Voluntary Life
	Varies	Voluntary Accident Voluntary Critically Illness Voluntary Hospital Indemnity Voluntary Home Insurance Voluntary Automobile Insurance Voluntary Pet Insurance
Standard Insurance Company 1100 South West Sixth Avenue Portland, OR 97204	642689	Long-Term Disability
Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670	12058969	Vision

Self-insured Component Plans	Contract No.	Type of Benefit
Delta Dental of Colorado 4582 South Ulster Street, Suite 800 Denver, CO 80237	W2871	Dental – EPO Dental - PPO
Denver Public Schools Attn: Director of Benefits	—	Wellness Program *(integrated with UHC medical)*

Self-insured Component Plans	Contract No.	Type of Benefit
1860 Lincoln Street, 11th Floor Denver, CO 80203		
Health Equity/Wage Works 15 West Scenic Point Drive, Suite 100 Draper, UT 84020	—	General-Purpose Health FSA Limited Purpose Health FSA Dependent Care FSA Commuter Benefits Health Savings Accounts (HSA) COBRA Administration
Kaiser Foundation Health Plans, Inc. 1 Kaiser Plaza Oakland, CA 94612	47077	Medical – CDHP (HSA compatible) Medical – Deductible HMO
MotivHealth 10421 South Jordan Gateway, Suite 300 South Jordan, UT 84095	DPS0007AS	Medical – HDHP (with HSA)
Unitedhealthcare 9900 Bren Road East Minnetonka, MN 55343	930447	Medical – CDHP (HSA compatible) Medical – Deductible HMO

Denver Public Schools Wellness Program: The School offers one or more voluntary wellness programs or disease management programs ("Wellness Program") under this Plan that are reasonably designed to promote the health and wellbeing of covered individuals. Participation in the Wellness Program is completely voluntary and the School pays the full costs necessary to provide wellness benefits (although participants may be required to invest in up-front items such as planning, outside counselors or resources, and/or any necessary equipment such as pedometers or scales for weigh-ins). The Wellness Program may offer certain incentives or rewards for participation in a wellness activity or activities, or for satisfying certain health standards. The terms and conditions of the Wellness Program will be communicated to you during your enrollment period and it will be administered in compliance with all applicable laws. To obtain more information regarding the Wellness Program contact the School's Director of Benefits at 720-423-3864.

Refer to the "Wellness Program" Section of this EPS for more information about a participant's right to a "Reasonable Alternative Standard" when a Wellness Program requires participants to satisfy a standard related to a health factor that is "activity-only" or "outcome-based."

APPENDIX B

DENVER PUBLIC SCHOOLS EMPLOYEE BENEFIT PLAN

EMPLOYEE PLAN SUMMARY

Claims Administrator Contact Information

Use the address and phone number provided on your ID Card if different.

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	**Phone No.**	**Online**
Medical – Kaiser	Kaiser Permanente Attn: Claims Administration PO Box 30547 Salt Lake City, UT 84130 *Claims Appeals:* Kaiser Permanente 3701 Boardman Canfield Road, Bldg. B Canfield, OH 44406	877-883-6698	www.kp.org *Wellness Program:* rewardscustomerservice@kp.org
Medical – MotivHealth	MotivHealth Attn: Claims Administrator 10421 South Jordan Gateway, Suite 300 South Jordan, UT 84095	844-234-4472	www.motivhealth.com/dps
Medical – UHC	UHC Attn: Claims Department PO Box 740800 Atlanta, GA 30374-0800	877-844-4999	member.uhc.com/myuhc
Dental	Delta Dental Attn: Claims Department PO Box 173803 Denver, CO 80217-3803 *Appeals* Delta Dental Attn: Appeal Department PO Box 172528 Denver, CO 80217-2528	303-741-9305	www.deltadentalco.com
Vision	VSP Attn: Claims Department 3333 Quality Drive Rancho Cordova, CA 95670	800-877-7195	www.vsp.com

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	**Phone No.**	**Online**
FSA Commuter Benefits HSA COBRA Benefits	HealthEquity/Wage Works Attn: Claims Department 15 West Scenic Point Drive Suite 100 Draper, UT 84020	877-924-3967	wageworks.com
EAP	ComPsych Attn: Member Services 455 North Cityfront Plaza Drive Chicago, IL 60611	855-327-1377	www.guidanceresources.com Organization Web ID: DPS
Life/AD&D	MetLife Attn: Group Life Claims PO Box 6100 Scranton, PA 18505-6100	800-638-6420	www.metlife.com/mybenefits
Long-Term Disability	The Standard Attn: Employee Benefits Dept. PO Box 2800 Portland, OR 97208	800-368-1135	www.standard.com
Prepaid Legal	MetLaw Attn: Claims Department 1111 Superior Avenue Cleveland, OH 44114	800-821-6400	login.legalplans.com
Voluntary Accident Voluntary Critical Illness Voluntary Hospital Indemnity Voluntary Home Insurance Voluntary Automobile Insurance Voluntary Pet Insurance	MetLife Attn: Claims Department PO Box 80826 Lincoln, NE 68501-0826	800-438-6388	www.metlife.com/mybenefits