

# **BOULDER VALLEY SCHOOL DISTRICT BENEFITS PLAN**

**July 1, 2009**

This document together with the applicable group insurance contracts, plan documents and certificate insurance booklets, constitute the Summary Plan Description / written plan document for the Boulder Valley School District Benefits Plan.

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## 1. Introduction

Boulder Valley School District (“Plan Sponsor”) maintains the Benefits Plan (the “Plan”) for the exclusive benefit of eligible Employees and their eligible Dependents. Currently, these benefits are provided under various insurance contracts entered into by the Plan Sponsor for the Plan. The Plan benefits are summarized in the Certificate of Insurance booklets issued by the applicable insurance companies. This document, together with the Certificate of Insurance and Benefits booklets constitutes the Summary Plan Description.

## 2. General Information about the Plan

Plan Name:	Boulder Valley School District Benefits Plan
Type of Plan:	Benefits Plan providing medical, prescription drug, dental, voluntary vision, Group Life & AD&D, Group LTD and Section 125 Flexible Spending benefits.
Plan Year:	The fiscal records of the Plan are kept on a contract year basis ending June 30 (Section 125 Flexible Spending benefits fiscal records are kept on a calendar year ending December 31.)
Funding Medium and Plan Administration:	<p>The Plan provides fully insured and self-funded benefits to Eligible Employees and their Dependents.</p> <p><b>Fully Insured</b> - Fully insured benefits are provided under group insurance contracts entered into between the Plan Sponsor and the insurance companies identified in this document. Claims for benefits are to be sent to the appropriate insurance companies, which are responsible for paying claims, not the Plan Sponsor. Note that the insurance companies and the Plan Sponsor share responsibility for administering the plans.</p> <p><b>Self-funded</b> - Self-funded benefits: the Plan is administered through the local office of the Plan Sponsor and third party administrator(s) (TPA).</p>

Plan Sponsor & Plan Administrator:	Boulder Valley School District
Plan Sponsor's Employer Identification Number:	846014683
Medical, Dental & Vision Insurance Company or Third Party Administrator:	Fully insured medical, prescription drug & voluntary vision – Kaiser Self-funded medical, prescription drug – Great-West/CIGNA Self-funded dental – Delta Dental Fully insured voluntary vision–VSP
Group Life & AD&D Insurance Company:	CIGNA Group Insurance
Group Long-Term Disability Insurance Company:	Sun Life of Canada (in addition to coverage provided by Colorado PERA).
Section 125 Flexible Spending and COBRA Third Party Administrator:	Planned Benefit Systems
Named Fiduciary & Agent for Service of Legal Process:	Boulder Valley School District

The written plan document consists of this document, together with group insurance contract(s) entered into between the Plan Sponsor and the insurance companies.

***Important Disclaimer: The fully insured benefits hereunder are provided pursuant to Insurance Contracts between the Plan Sponsor and the applicable insurance companies. If the terms of this document conflict with terms of the applicable Insurance Contract, the terms of the Insurance Contract will control, unless superseded by applicable law.***

### **3. Eligibility and Participation Requirements**

To determine whether you and your Dependents are eligible to participate in the various benefit options offered by the Plan, please read the eligibility information contained in the certificates of insurance, benefit plan documents, negotiated agreements and on the district web site. Eligible Employees must complete an application form to enroll and pay the required premium, if applicable.

### **4. HIPAA Rights for Health Care Benefits**

Under HIPAA (the Health Insurance Portability and Accountability Act of 1996), if you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health insurance coverage, you may, in the future, be able to enroll yourself or your Dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a 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. The Plan shall issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

- (a) For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage shall be issued with the COBRA notice sent after the Qualifying Event.
- (b) For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable Coverage shall be issued as soon as reasonably possible after coverage ceases.
- (c) For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four (24) months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Participant (or by another person authorized by the former Plan Participant).

The Certificate of Creditable Coverage shall be in the form required by HIPAA. Also upon written request, the Plan shall provide a copy of the Plan Document and other information as outlined in the model form established by HIPAA to provide additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage. The Plan shall charge the requesting entity or individual a fee to cover the reasonable cost of providing this information.

## **5. USERRA Rights and Responsibilities**

The Federal Uniformed Services Employment and Reemployment Rights Act (USERRA), establishes for employers and certain Employees who terminate Service with the employer for the purpose of Uniformed Service. This includes the right to continue the medical, dental, vision and prescription drug coverage that you (the Employee) had in effect for yourself and your Dependents.

“Uniformed Service” shall include full-time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

You must notify the Plan Sponsor verbally or in writing of your intent to leave employment and terminate your Service with the Plan Sponsor for the purpose of Uniformed Service. The notice must be provided at least 30 days prior to the start of your leave, unless it is unreasonable or impossible for you to provide advance notice due to reasons such as military necessity.

Under USERRA, you are eligible to elect continued medical, dental, vision and prescription drug coverage for yourself and your Dependents when you terminate Service with the Plan Sponsor for the purpose of Uniformed Services.

The Plan Sponsor should establish reasonable procedures for electing continued medical, dental, vision, and prescription drug coverage and for payment of contributions. See the Plan Sponsor for details.

If you do not provide advance notice of your leave and you do not elect continued coverage prior to your leave, coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service. However, if you are excused from giving advance notice because it was unreasonable or impossible for you to provide advance notice due to reasons such as military necessity, then coverage will be retroactively reinstated if you elect coverage for yourself and your Dependents and pay all unpaid contributions within the period specified in the Plan Sponsor’s reasonable procedures.

If you provide advance notice of your leave but you do not elect continued coverage prior to your leave, coverage for you and your Dependents will terminate on the date that coverage would otherwise terminate due to termination of your Service, when the duration of Uniformed Service is at least 30 days. However, coverage will be retroactively reinstated if the Plan Sponsor has established reasonable procedures for election of continued coverage after the period of Uniformed Service begins, and you elect coverage for yourself and your Dependents and pay all unpaid contributions within the time period specified in the procedures. If the Plan Sponsor has not established reasonable procedures, then the Plan Sponsor must permit you to elect continued coverage for yourself and your Dependents and pay all required contributions at any time during the period of continued coverage, and the Plan Sponsor must retroactively reinstate coverage.

If the Plan Sponsor has established reasonable payment procedures and you do not make payments according to the procedures, then coverage for you and your covered Dependents will terminate as described in the procedures. During a leave for Uniformed Service, the period of continued coverage begins immediately following the date you and your covered Dependents lose coverage under the Plan, and it continues for a maximum period of up to 24 months.

If the period of Uniformed Service is less than 31 days, you are not required to pay more than the amount that you paid as an active Employee for that coverage for continued coverage. If the period of Uniformed Service is 31 days or longer, then you will be required to pay up to 102% of the applicable group rate for continued coverage. If you are entitled to COBRA continuation coverage, then the COBRA coverage period runs concurrently with the USERRA coverage period. In some instances, COBRA coverage may continue longer than USERRA coverage.

Coverage for an Employee who returns to Service with the employer following Uniformed Service will be reinstated upon request from the Employee and in accordance with USERRA. Reinstated coverage will not be subject to any exclusion or waiting period, if such exclusion and/or waiting period would not have been imposed had coverage not terminated as a result of Uniformed Service. For medical coverage, a pre-existing condition limitation may be imposed on an illness that is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, Uniformed Service. See the Plan Sponsor for details.

## **6. FMLA**

If the Plan Sponsor approves your FMLA leave pursuant to the Family and Medical Leave Act of 1993 (FMLA), coverage under the Plan will continue during your leave. Contributions must be paid by you (for dependents) and the Plan Sponsor. If contributions are not paid for your dependents, their coverage will cease. If your

approved leave extends beyond the FMLA time period, you may continue coverage by paying the full premium for yourself and your dependents (if applicable) as long as you are on an approved leave. If you have questions about FMLA leave, see the Plan Sponsor.

## **7. COBRA**

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA) requires that an Employee and/or Dependent may elect to continue coverage up to the length of time specified below after the occurrence of any of the following events which would normally result in termination of coverage under the Plan, provided they pay the full cost of Plan coverage, not to exceed 102% of the total cost (employer and employee) or 150% of the total cost during the 11-month extension for disability. Each Qualified Beneficiary, including the Employee, Spouse / Domestic Partner, or any Dependent covered under the regular Plan, may make an independent election for continuation coverage.

Coverage may be continued up to 18 months for an Employee and/or Dependent in the qualifying event of the termination of employment (other than by reason of gross misconduct) or the reduction of hours of an Employee. Continuation coverage may be extended from 18 months to 36 months for Dependent(s) who are qualified beneficiaries if during the 18-month period a second qualifying event occurs, such as the Employee dies, enrolls in Medicare, or divorces or legally separates from his Spouse / Domestic Partner. This extension may also apply upon the loss of Dependent status by a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the plan had the first qualifying event not occurred.

Continuation coverage may extend from 18 months to 29 months for you and/or your Dependent if one of you becomes totally disabled (as determined by the Social Security Administration under Title 2 or Title 16) at any time during the first 60 days of COBRA continuation coverage. However, you and/or your Dependent must give notice of the disability within 60 days of the Social Security determination and must request to extend the continuation period before the end of the first 18 months. If during the continuation coverage the Social Security Administration determines that the individual is no longer disabled, the individual must inform the Plan of this redetermination within 30 days of the date it is made. Coverage may be continued for up to 36 months for a Dependent in the event of:

- (a) Your death;
- (b) Your divorce or legal separation from your Spouse or Domestic Partner;
- (c) Your becoming entitled to Medicare, and as a result the loss of eligibility for coverage under the Plan by yourself and your Dependents;
- (d) The loss of Dependent status by a Dependent child under the terms of this Plan.

Coverage will be continued only for you and/or your Dependents who were covered under the Plan on the day immediately preceding termination. However, if a child is born to you or placed for adoption with you during the period of COBRA continuation coverage, your child is entitled to receive COBRA continuation coverage with independent COBRA rights.

Coverage will not be continued beyond the earliest of the following dates:

- (a) The date ending the period for which any required contribution has been paid;
- (b) The date you and/or your Dependent first become entitled to Medicare, or first become covered under another group health plan without being subject to that plan's pre-existing limitations;
- (c) The date your employer ceases to provide any group health plan.

If any provision of this section is contrary to the Consolidated Omnibus Reconciliation Act of 1985 (as amended), the provision is changed to comply with the law.

**Note:** All Plan Participants must notify the Plan Sponsor in writing within sixty (60) days of:

- (a) Divorce or legal separation
- (b) Covered Dependent child ceasing to qualify as a Dependent
- (c) Acceptance of Medicare or coverage under another employer's group health plan (whether or not as an Employee), if that plan does not limit coverage for pre-existing conditions.
- (d) Second qualifying event
- (e) Qualified Beneficiary's disability or cessation of disability
- (f) Death of the Employee

Written notice must be provided to the Plan Sponsor to forward to the designated COBRA Claims Administrator, if applicable. The notice must include the name of the Employee with identification number, Plan Name and Number, date and type of the qualifying event and name(s) of the applicable Dependent(s).

**FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.**

## **8. Summary of Plan Benefits**

The Plan provides Eligible Employees and their Dependents, if applicable, with medical, dental, long-term disability and life insurance benefits (and Voluntary Vision beginning 9/1/2009). The insured benefits are provided under group insurance contracts entered

into between the Plan Sponsor and the insurance companies. A summary of the benefits provided under the Plan is set forth in the Certificate of Insurance booklets and Schedules of Benefits.

This Plan shall provide benefits in accordance with the applicable requirements of Federal laws, such as COBRA, and the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act.

This Plan will also provide benefits as required by any qualified medical child support order. A copy of the procedures governing qualified medical child support orders (QMCSOs) may be obtained without charge from the Plan Administrator. This Plan will also provide benefits to Dependent children placed with Participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants or beneficiaries.

Under the Federal Law entitled Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group insurance coverage generally may not 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 normal 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 (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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Federal Law entitled the Women's Health and Cancer Rights Act requires coverage for reconstructive surgery following mastectomies. Accordingly, this Plan shall provide, in a case of a Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction with such mastectomy, coverage for:

- (a) reconstruction of the breast on which the mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and benefit percentage provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

The Mental Health Parity Act of 1996 (MHPA) prohibits employers from imposing lower annual or aggregate lifetime dollar limits on mental health benefits than are imposed on medical and surgical benefits. Group health plans with lifetime or annual spending limits

for medical or surgical services must include mental health benefits in the limit or use a separate limit for mental health benefits that is no more restrictive than the limit placed on medical and surgical benefits. If medical/surgical benefits have varying limits, then the limit on the mental health benefit would be a weighted average.

## **9. How the Plan is administered**

The administration of the Plan is under the supervision of the Plan Administrator, the Plan Sponsor and the duly authorized person(s) who acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them. Any duly authorized officer of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan. The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a claims fiduciary to receive, review, and process claims for benefits. The Plan Sponsor bears the incidental costs of administering the Plan.

This Plan provides fully insured benefits that are provided under a group insurance contract entered into between the Plan Sponsor and the applicable insurance companies. Claims for the insured benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims, not the Plan Sponsor.

The applicable insurance company or claims administration firm is responsible for:

- (a) Determining eligibility for and the amount of any benefits payable under the Plan.
- (b) Prescribing claims procedures to be followed and the claims forms to be used by Employees pursuant to the Plan.

Those entities also have the authority to require Employees to furnish them with such information deemed necessary for the proper administration of the Plan. If you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the applicable insurance company or claims administration firm.

For the self-funded benefits, the Plan Sponsor has broad discretionary authority to interpret Plan terms, to determine the status and rights of participant beneficiaries and other persons, to make final and binding determinations as to eligibility and benefits, to prescribe administrative procedures, to gather needed information, to employ or appoint persons to help or advise in any administrative functions, to appoint investment managers and trustees and generally to do all other things needed to operate, manage and administer the Plan.

The Plan has other fiduciaries, advisors and service providers. The Plan Sponsor may allocate fiduciary responsibility among the Plan's fiduciaries and may delegate fiduciary or other responsibilities to others. Any allocation or delegation must be done in writing and kept within the records of the Plan.

Each fiduciary is solely responsible for its own improper acts or omissions. By law, no fiduciary has the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon the other fiduciary. Nor is a fiduciary liable for a breach of fiduciary duty committed before it became, or after it stopped being, a fiduciary. The medical and prescription drug ~~and limited vision~~ benefits are provided pursuant to a stop-loss insurance contract issued by Great-West /CIGNA. Great-West/CIGNA is the Third-Party Administrator for these Plan benefits. Delta Dental is the Third-Party Administrator for the dental benefits and Planned Benefit Systems is the Third-Party Administrator for the Section 125 Flexible Spending benefits. The Plan Sponsor has delegated to these Third-Party Administrators its entire discretionary authority to determine eligibility for benefits and the amount of benefits due, to construe the terms of the contract, and generally to do all other things needed to administer the contract. The Plan Sponsor retains all of its other authority.

### **Waiver**

Failure by the Plan or Plan Sponsor to insist upon compliance with any provisions of the plans at any time or under any set of circumstances shall not operate to waive or modify the provision or in any manner render it unenforceable as to any other time or as to any other occurrence, whether the circumstances are, or are not, the same. No waiver of any term or condition of the Plan shall be valid unless contained in a written memorandum expressing the waiver and signed by a person authorized by the Plan Sponsor to sign the waiver.

### **10. Circumstances Which May Affect Benefits**

A Participant may make a new election upon the occurrence of certain events as described as a Change in Status event. A Participant means a person who is an Eligible Employee and who elects one or more of the insurance benefits and elects to pay for his or her share on a pre-tax salary basis (premium payment benefits), health flexible spending arrangement benefits or dependent care assistance program. Change in status means any of the events described below, as well as any other events included under subsequent changes to Code §125 or regulations issued thereunder, which the Plan Sponsor, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan. The change in status is only allowed if such election change is made on account of and corresponds with a change that affects eligibility for coverage under a plan of the Plan Sponsor or Dependent's employer (referred to as the general consistency requirement). A Participant may

change an election as described below upon the occurrence of the stated events for the applicable components of this Plan:

A change in a Participant's legal marital status, including marriage, divorce, legal separation, annulment or death of a spouse;

Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, court ordered change in legal custody status or Qualified Medical Child Support (QMCSO) or death of a dependent;

Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from a Family and Medical Leave Act (FMLA) or other approved unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefit plan.

An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit such as attaining a specified age, marriage, or any similar circumstance;

Entitlement to/or loss of Medicaid or Medicare coverage by an Employee, employee's Spouse or eligible Dependent;

A change in the place of residence of the Participant or his or her Spouse or Dependents;

An Employee may make a prospective election change during the plan year if the change corresponds with an open enrollment period change made by the employee's Spouse or qualified Dependent, provided that the election change is consistent with the changes under the other group plan; or

Significant change in available benefits and/or their cost, i.e. if a fully insured health plan imposes change in benefit coverage levels or increases premiums substantially, this would qualify as a change in status event; however, a Plan Sponsor's change in contribution amounts would not apply. Note: This does not allow election changes in the health flexible spending arrangement benefits.

Please check with the Plan Sponsor as not all Change in Status events listed apply to all components of the Plan (premium payment benefits, health flexible spending arrangement benefits or dependent care assistance program).

Your eligibility for Plan benefits terminates on the last day of the month that you terminate from employment with the Plan Sponsor. For less than 12 month employees who complete their entire contract, coverage ends at the end of the contract year. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or if you submit false claims (see the Certificate of Insurance booklet and/or Schedules of Benefits for more information). Coverage for your Spouse / Domestic Partner and Dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Certificate of Insurance booklet and/or Schedules of Benefits, such as divorce, child attains age limit, child gets married, etc. Benefits will also cease for Employees, Spouses / Domestic Partners and Dependents upon termination of the Plan.

Depending on the reason why coverage was terminated, you and your covered Spouse / Domestic Partner and Dependents may have the right to continue coverage temporarily under COBRA. See Section 7 for information about COBRA rights.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions due to pre-existing conditions, and exclusions for certain medical procedures) are described in the Certificate of Insurance and Schedules of Benefits booklets. Please read the booklets carefully. See also any Plan notices and other important information about the exclusions due to pre-existing conditions and special enrollment rights you may have. Please see <http://bvsd.org/benefits/Pages/default.aspx> or contact the Plan Sponsor if you need another copy.

#### 11. Right to Receive Medical Information Necessary to Determine Benefits

By accepting coverage under this Plan, Eligible Employees and their Dependents agree to supply information about medical conditions and records or other coverage when requested by the Plan. All private health information will be used on a need only basis for purposes as describe in the *Boulder Valley School District Privacy Policy Disclosure*.

#### **12. Amendment or Termination of the Plan**

The Plan Sponsor shall have the unlimited right to modify, amend, terminate, or merge the Plan at any time without prior written notice to any Participant. Any such amendment, termination, or merger shall be documented in writing by an authorized representative of the Plan Sponsor and shall become effective as of the date specified in the appropriate documentation. Any such amendment, termination or merger shall be

binding upon all Employees and Dependents (including those Participants on continuation coverage).

No change in this Plan will be valid unless it is approved by the Plan Sponsor or the duly authorized representative of the Plan Sponsor. Any such change must be endorsed by the Plan Sponsor or the duly authorized representative of the Plan Sponsor and attached to this Plan Document. An amendment to this Plan may be retroactively effective, but shall not adversely affect the rights of a Participant under this Plan for benefits provided after the effective date of the amendment but before the amendment is adopted.

Additionally, the Plan Sponsor reserves the right to determine the level of contribution required from Participants for Plan coverage.

### **13. No Contract of Employment**

The Plan shall not be deemed to constitute a contract between the Plan Sponsor and any Participant or to be consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Participant or Employee at any time, "subject to the terms of any collective bargaining agreement," regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

### **14. Claim Procedures**

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company or Third Party Administrator will decide your claim in accordance with its reasonable claims procedures. The insurance company 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 insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or Third Party Administrator for a review of the denied claim. The insurance company or Third Party Administrator will decide your appeal in accordance with its reasonable claims procedures. If you do not appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the Certificate of Insurance or booklets for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.

## **15. Statement of Rights**

All Participants of this Plan are entitled to the following rights and protection under the Plan:

### **Receive Information about Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

### **Continue Group Health Plan Coverage**

The Employee and qualified beneficiaries may continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. COBRA participants may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

If there is creditable coverage from another plan, reduction or elimination of exclusionary periods of coverage for pre-existing conditions, if applicable, shall be allowed under this group health plan. Participants should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer when they lose coverage under the plan, when they become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested before losing coverage, or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, Participants may be subject to a pre-existing condition

exclusion for 12 months (18 months for Late Enrollees) after the enrollment date for coverage.

### **Prudent Actions by Plan Fiduciaries**

The people who operate the Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of the Employee and other Plan Participants and beneficiaries. No one, including the Plan Sponsor, a union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit.

### **Enforcement of Rights**

If a claim for a welfare benefit is denied or ignored, in whole or in part, Participants have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

### **Assistance with Your Questions**

If there are any questions about this Plan, contact the Plan Administrator.

## **16. Summary and Protected Health Information**

Boulder Valley School District is the Plan Sponsor and Plan Administrator of this Plan. Your Plan, any business associate servicing your Plan, or the claims administration cannot disclose protected health information to your Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of your Plan has agreed to abide by these provisions.

### **Disclosure of Summary Health Information**

This Plan, any business associates servicing your Plan, or the claims administrator will disclose protected health information to your Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by your Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the “Restrictions on Plan Sponsor’s Use and Disclosure of Protected Health Information” and “Adequate Separation Between the Plan Sponsor and the Plan” sections that follow.

Neither your Plan, nor the claims administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor unless the

disclosures are explained in the *Boulder Valley School District Privacy Policy Disclosure*.

Neither your Plan, nor the claims administrator, nor any business associate servicing your Plan will disclose protected health information to your Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

### **Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information**

Your Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan Participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by your Plan to account for disclosures in accordance with 45 CFR § 164.528; and
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to your Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, your Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, your Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

## **Adequate Separation between the Plan Sponsor and the Plan**

Certain individuals under the control of your Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the claims administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the claims administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance.

## **Security of Electronic Protected Health Information**

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure Participants' protected health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards including:

- a) unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic protected health, or
- b) unauthorized interference with the system operations in the sponsor's information systems that contain or provide access to the Plan's electronic protected health information.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

## 17. Legal Compliance/Conformity

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws of the Plan Sponsor's principal place of business to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Plan Sponsor's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

No clerical errors made by the Plan Sponsor, Plan Administrator, or the claims administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made. If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

## 18. Definitions

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

**Eligible Dependent** means an individual who meets the requirements for such status as defined by the applicable certificates of insurance.

**Eligible Employee** means a person who is an Employee of the Plan Sponsor, regularly scheduled to work sufficient hours for the Plan Sponsor in an Employer/Employee relationship and who meets the requirements for such status as defined by the applicable certificates of insurance.

**Medicare** is the Health Insurance for the Aged and Disabled program under Title XL of the Social Security Act, as amended.

**Participant** is a person covered under this Plan or the legal representative or guardian of a minor or incompetent person covered under this Plan.

**Plan** means the Boulder Valley School District Benefits Plan, which is a benefit plan for eligible employees of Plan Sponsor.

**Plan Administrator or Plan Sponsor** is Boulder Valley School District.

**Plan Year** is the fiscal records of the Plan are kept on a contract year basis ending on June 30. (Section 125 Flexible Spending benefits fiscal records are kept on a calendar year ending December 31.)