DENVER HEALTH
est. 1860
FOR LIFE'S JOURNEY

2019 EMPLOYEE BENEFITS

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2019 Open Enrollment is October 12, 2018 – October 31, 2018

JOIN US! Employee Benefits/Vendor Fair

All benefit vendors will be available to answer your questions and provide you with plan materials during the Benefit Vendor Fair. Benefits staff will also be available to answer questions.

Employee Benefits Fair

Wednesday, October 17
10:00 a.m. – 1:30 p.m.
Pavilion C, Sabin Classroom

Health Advocate Call Center

The Health Advocate Call Center is available to help you 24/7 at **866-799-2728** or **HealthAdvocate.com/members**. Health Advocate can assist you with:

- Questions about your benefit choices and options
- Finding a Doctor
- Scheduling an appointment
- Resolving claim issues
- Prior Authorizations
- Transferring medical records
- Help with eldercare
- Information on procedures, diagnosis, and medical second opinions

Open Enrollment Is A Good Time To Review All Your Benefits!

Every year, eligible employees are given an opportunity to change their benefit elections for the upcoming benefit plan year. The 2019 Open Enrollment period is for plan year January 1 to December 31, 2019, and is your opportunity to:

- Change from one health plan or dental plan to another
- Add eligible dependents not currently covered
- Drop current dependents
- Enroll or cancel coverage
- Required re-enrollment in Flexible Spending Accounts (FSA)

Open Enrollment is the only time of the year that you can change from one health or dental plan to another.

All benefit-eligible employees who are going to make Open Enrollment changes will be required to make those changes through the **Lawson Self-Service Portal**.

You must re-enroll in the Flexible Savings Account (FSA) for the new plan year. FSA elections do not carry over from one plan year to the next. If you are not making changes to your benefits for 2019, and are not in a FSA, you do not need to do anything.

Adding Dependents

If you are planning to add any **new** dependents to your benefit plans, you must provide the appropriate documents to prove that these dependents are eligible for coverage (marriage licenses to add a spouse, and birth or adoption certificates to add dependent children). These documents along with the dependent's name, Social Security number, and date of birth need to be provided to the HR Employee Benefits Center before you can add them to your plan(s) online. See page 39 for the Employee Benefits Center contact information.

We've Continued the Following Benefits for 2019 in All Three Medical Plans:

- Occupational, physical and speech therapy copays have been waived at Denver Health, after you've met your annual deductible if applicable.
- MRI copays will continue to be waived for care received at Denver Health, after you've met your annual deductible if applicable.
- In all three medical plans, when care is received at Denver Health, there are **three free** PCP visits per year.
- $10 copay for behavioral health visits, when care is received at Denver Health, after you've met your annual deductible if applicable.

Medical Coverage

DHHA Medical Care HMO: There are no plan changes for the DHHA Medical Care HMO, and premium rates will remain the same as 2018.

HighPoint HMO: The HighPoint HMO will now have a $100 Individual / $200 per family deductible annually. Aside from preventative care, and three PCP visits at Denver health, lab work, medication, specialists visits will be subject to the $100 / $200 deductible before the co-pay schedule applies. The HighPoint HMO will have an annual Out-of-Pocket Maximum of $5,000 per individual, and $10,000 per family. This is the maximum amount that you could pay out-of-pocket in a year for approved in-network treatment.

HighPoint POS: The HighPoint POS plan will have an annual Out-of-Pocket Maximum of $5,000 per individual, and $10,000 per family. This is the maximum amount that you could pay out-of-pocket in a year for approved in-network treatment. All deductibles, copays, and coinsurance that you pay will count toward the annual Out-of-Pocket Maximum.

While we remain extremely competitive, rates for the HighPoint HMO and PPO plans will increase next year. The level of increase depends on the plan you choose and additional details can be found on page 13.

Remember, in all three plans, **when care is received at Denver Health** there are three free primary care visits; a $10 copay for behavioral health visits; and copays are waived for occupational therapy, physical therapy, speech therapy and MRIs.

About Our Networks

Denver Health provides you with three different provider network options. Employees who choose the Denver Health HMO pay lower premiums, pay less for services when received, and can always be referred to a specialist or facility out of network if Denver Health providers are not available.

- **DHHA Medical Care HMO** (Denver Health)
- **HighPoint HMO** (Denver Health, University of Colorado, and Children's hospitals and affiliated network providers)
- **HighPoint Point of Service** (HighPoint HMO network plus Cofinity network facilities and providers)

DispatchHealth is now in the Denver Health Medical Plan

DispatchHealth is now in the Denver Health Medical Plans.

What is DispatchHealth? It's a house call by providing patients a way to access convenient, high-quality acute care in the comfort of their home. DispatchHealth offers services from treating the common flu to minor fractures to suturing to advanced blood laboratory testing and much more. They are available from 8 a.m. to 10 p.m., 7 days a week, 365 days a year, including all holidays. Providers are board certified physicians, nurse practitioners, and physician assistants. Your cost as a DHMP member is $50 copay per visit.

To Request Care

- Go online to **www.dispatchhealth.com**
- Call **303-500-1518**

Dental Coverage

Delta Dental of Colorado: No changes to premiums or coverage for 2019

Vision Coverage

VSP: No changes to premiums or coverage for 2019

Note – The Denver Health Benefits staff has made every effort to ensure the accuracy of the information in this booklet. In the event of a discrepancy, and in all instances, the plan documents and contract shall prevail. To obtain a copy of the plan documents, contact the HR Employee Benefits Center at 303-602-7000. This booklet does not constitute a contract, either express or implied, between Denver Health and any employee.

Life Insurance and AD&D (Basic and Voluntary)

- Denver Health provides employees with one times their annual salary in Life and Accidental Death and Dismemberment insurance. Employees can also purchase additional Term Life insurance at discounted group rates.
- No changes to premiums for 2019
- Unum will be the new carrier for Life and Disability coverages effective in 2019.
- Basic Life Benefit will change from 2x annual salary to 1x annual salary in 2019. To give you the opportunity to replace this loss in coverage, you will be able to elect supplemental coverage up to $250K.

Disability Plans

- **Short-Term Disability (STD):** No changes to premiums or coverage for 2019.
- **Long-Term Disability (LTD):** No changes to premiums or coverage for 2019. LTD Buy-Up is available during this open enrollment without medical underwriting up to the Guarantee Issue amount.

How to Access Open Enrollment Online

Benefit-eligible employees will be enrolling and/or making changes to their benefit selection through our online system, the Lawson Employee Self-Service Portal or Lawson. This is the same Lawson Portal used to view paychecks. You can visit this site at any time during the year to review other employee information, including your address for Payroll and Human Resources mailings, current benefits coverage, PTO balance, paycheck data, training information, job profile, PPD expiration date, etc.

If you are unable to use your password, or are having trouble with your log in, please call the HelpDesk at **303-436-3777**. If you are not able to complete your enrollment through Lawson, contact the HR Benefits Center at **303-602-7000**.

Lawson Online Benefits Enrollment Instructions

1. If you do not know what your current benefits are, log onto the Lawson Portal and click on *Current Benefits*. Note: If you do not wish to make any changes, and you won't be participating in any of the Flexible Spending Accounts, then you do not need to do anything regarding Open Enrollment.

2. **If you are adding new dependents (who are not currently listed in Lawson) to the medical, dental or vision plans, you will need to update this information with the HR Benefits Center before you access or make changes in Lawson. You will also need to provide the HR Benefits Center with appropriate documentation of dependent status (original or certified copies of marriage license to add your spouse, or birth certificates to add eligible dependent children before the end of open enrollment). You will also need to provide the dependent's date of birth and Social Security number.**

3. If you are canceling your health insurance and waiving health coverage and your FTE status is .75 or greater, you will be required to provide the HR Benefits Center with proof of other coverage before your waiver will be processed. If proof of other coverage is not received by November 15, 2018, your waiver will not be processed, and your current coverage will remain in effect for next year. Any other requested changes will be processed normally.

Accessing the Lawson Employee Self-Service Portal

USERNAME/PASSWORD INFORMATION

Your username and password for the Lawson Portal are the same as your network login. If you don't remember your username and/or password, contact the Help Desk at **303-436-3777**.

To access the Lawson Portal, go to the main page of the Pulse and type **LawsonGetItNow** in the address line. You can also access the Lawson Portal from your home computer via **DenverHealth.org/ForEmployees**. Note: If you have an Apple/Mac computer, you will not be able to access Lawson from home.

Select the *Benefits Enrollment* link under *Benefits*, from the *Employee Self Service (ESS)* menu on the left side of the screen. Please review the first screen that contains a welcome notice, an acknowledgement regarding your benefits information, and a notice of privacy practices. Also included is a definition of eligible dependents under the plans and the required documentation needed to add dependents to the plan, as well as an acknowledgement of dependent eligibility.

Press *Continue* to begin the enrollment process to change or confirm your elections. Enrollment in the Benefits Plans is in the following order: Medical, Dental, Legal Plan, Vision, Flexible Spending Accounts, Long-Term Disability and Short-Term Disability. Press *Continue*.

The next screen shows the benefits you are currently enrolled in. It also will tell you which dependents, if any, are enrolled in the medical and dental plans. Press *Continue*.

- For each plan you will have the following choices to select from:
  - ***Keep the Same Coverage*** – no changes to this plan. If you selected *Keep the Same Coverage,* and press *Continue* you will receive a confirmation of your selection. If this is correct, press *Continue*. If this is not correct, press *Previous* to change your selection. By pressing *Elections* you will see all of your elections at this point.
  - ***Change the Coverage*** – within the same plan, change the coverage level, i.e., Single to Family. If you selected *Change the Coverage*, you will be asked to select the coverage level you want to enroll in, and then press *Continue.* You will then be asked to select the dependents you want to cover in the plan. Press *Continue* and the next screen will show you what plan and coverage you have selected along with the dependents enrolled in the plan. If your selections are correct, press *Continue,* if not, press *Previous* to change your selection.
  - ***Add or Change Dependent*** – If you are adding new dependents to your benefit plans, you must provide the appropriate document, as described on page 4, to the HR Employee Benefits Center before you will be able to add them to your benefits for the next plan year.

» ***Select a Different Plan*** – to change the plan (for example, Denver Medical Care Plan to HighPoint Point of Service) or you will use this option to cancel or stop this benefit by selecting *No Coverage*. If you choose S*elect a Different Plan*, you will see the available plans, including the *No Coverage* option. Select the plan you want to enroll in, and press *Continue*. The next screen provides the coverage level available under this plan. Make your selection and press *Continue*. The next screen will ask which dependents you want to cover. If you have no dependents, then the next screen will show you the plan and coverage you selected along with the dependents enrolled in the plan, if applicable. If your selections are correct, press *Continue*, if not, press *Previous* to change your selection.

To see a brief summary of the current plan type, click on the plan name underlined and highlighted in blue.

Once you have completed the enrollment process you will be taken to a confirmation screen that indicates elections that will go into effect January 1, 2019. Please review this screen carefully. If your elections are correct, please select *Continue* to save your changes and press *YES* to print your confirmation statement or have a copy emailed to you. If you need to make corrections, select *Make Changes* and correct as necessary.

Keep a copy of your final confirmation once completed. Should there be problems with your 2019 benefits, the HR Benefits Center will be unable to make corrections without a copy of the final confirmation.

Once you have saved your changes, close your browser completely by using the *LOGOUT* button in the upper right of the screen.

If you have questions or problems, contact the HR Benefits Center at **303-602-7000**.

You can enter the Lawson Portal and make as many benefit election changes as often as you like from October 12 – October 31. The last changes made and saved, will be the benefits that will be effective on January 1, 2019.

Eligibility

Who's Eligible For Benefits?

- Full-time employees who regularly work 40 hours a week.
- Part-time employees who work between 20 and 39.9 hours a week.

Who is an Eligible Dependent?

- A legal spouse, common-law spouse, domestic partner, or Colorado Civil Union.
- A married or unmarried child, aged 26 and younger.
- An adopted child or a child placed with you for adoption.
- An unmarried child for whom you or your spouse has court-ordered custody or legal guardianship.* A notarized statement from family members is not sufficient to establish a legal guardianship.*

*Legal guardianship is established by the court, whereby a minor child is placed under the supervision of a guardian who, under the terms of the legal guardianship, is legally responsible for the care and custody of the child. It allows the guardian to access services for the child, something that would not be possible without the legal guardianship status.

Who is NOT an Eligible Dependent?

- An ex-spouse, ex-common-law spouse, an ex-domestic partner, an ex-Colorado Civil Union, a parent or parent-in-law.
- Grandchildren, siblings, nephews, nieces, cousins, aunts, uncles and grandparents.

*Only dependents who meet the definition of eligible dependent can be enrolled in Denver Health benefit plans.

If you have children on the plan who are not eligible dependents, you must provide the HR Benefits Center with legal guardianship and/or adoption paperwork as soon as possible or drop them from the plan immediately. Knowingly adding, or not removing, ineligible individuals from your Denver Health medical, dental and vision plans is considered insurance fraud. Employees committing insurance fraud may be terminated from employment and reported to the State of Colorado Insurance Commissioner. In addition, the employee may be liable to repay premiums to Denver Health and Hospital Authority and/or expenses incurred by the Denver Health Medical Plan, Inc.

Questions Regarding Benefits Eligibility?

Contact the HR Employee Benefits Center at **303-602-7000**.

When Can I Change My Benefits?

The only time you may change your benefit elections is during the annual Open Enrollment period, or if you experience a Qualifying Life Event as defined by the IRS during the plan year. Following is a list of life event changes. If you experience an event and wish to change your benefits as a result, please contact the Benefits department.

A life event or family status change is also known as a Qualifying Life Event. To change benefits under a Qualifying Life Event, you will need to complete and submit an Election Form and provide the appropriate documentation shown in the table below within 31 days from the Qualifying Life Event date. If you do not make your change within the 31-day period, you will not be allowed to make a change until the next Open Enrollment period or your next Qualifying Life Event. A Qualifying Life Event does not allow you to make plan-to-plan changes.

Qualifying Life Event	Documentation Needed	Changes That Can Be Made
Marriage	Marriage License or Certificate	Can add new dependents to existing plans; enroll in health, dental, and vision plans; increase FSA amounts. Can remove dependents or drop plans, if gaining other coverage.
Common Law Marriage	Affidavit of Common Law Marriage	
Registration of Domestic Partnership	Affidavit of Domestic Partnership	
Colorado Civil Union	Affidavit of Domestic Partnership	
Legal Separation	Legal Separation Order	Allows for removal of all ineligible dependents from current plans. Decrease FSA amounts. Cannot switch plans or enroll in new plans.
Divorce	Final Divorce Decree	
Dissolution of Common Law Marriage		
Dissolution of Colorado Civil Union		
Dissolution of Domestic Partnership	Statement of Termination of Domestic Partnership	
Birth (covered for first 30 days parents must enroll for coverage to continue)	Birth Certificate or Hospital Certificate	Can add spouse/domestic partner and newborn to existing plan. Increase FSA amounts. Cannot switch plans, or remove dependents.
Adoption	Adoption Court Papers	
Legal Guardianship – Custody of Dependents	Final Court Decree	
Death of a Dependent	Certified Copy of Death Certificate	
Termination or Commencement of Spouse's Employment	HIPAA Certificate, COBRA Notice or Letter from Spouse's Previous Employer*	Can add spouse and dependent children to health, dental and vision benefits. Enroll/increase FSA. Must provide proof coverage lost in last 31 days.
Change in Spouse's Employment Status		
Significant Change in Spouse's Health Care Coverage Due to Spouse's Employment		
Change in Employment Status from a Non-benefit eligible to Benefit-eligible Position	Copy of PAR/ePAR	Enroll in all benefit options.
Dependent Reaching Ineligible Age	No documentation required	Remove ineligible dependent; decrease FSA.
Medicare Eligibility for You or Your Spouse	Proof of Medicare Eligibility must be within 31 days	Opt out of health, dental, vision benefits, and decrease FSA.
Medicare Eligibility for Your Dependent(s)		

* Letters must be on the business letterhead and provided by a Human Resources representative. The letter must provide appropriate information to determine if the employee previously had health insurance and when the health insurance coverage ended. It is the employee's responsibility to make sure the information provided is sufficient and accurate.

DHMP Health Plans

Denver Health employees can obtain detailed plan materials for the health plans from the Employee Benefits subsite on the Pulse, from the Denver Health Medical Plan at **303-602-2100**, from the HR Benefits Center, or at the Employee Benefits/Vendor Fair.

Employees have the choice of three medical plans under the Denver Health Medical Plans: DHHA Medical Care HMO (DMCP), HighPoint HMO, and HighPoint Point of Service (POS).

DHHA Medical Care HMO	HighPoint HMO	HighPoint POS
Most cost effective option	Broader choice when selecting providers	Maximum freedom of choice when selecting a provider
• Utilize Denver Health physicians and services • Columbine network for chiropractic • Cofinity providers are in network for mental health services only • **If needed services are not available through the Denver Health network, or you are not able to see a provider within a specific timeframe, you will be referred to an appropriate out of network provider without any additional charge to you** See online directory for a complete list of current providers: **www.denverhealthmedicalplan.org/**	• Utilize Denver Health physicians and services • University of Colorado Hospital and Children's Hospital Colorado providers and facilities including Colorado Pediatric Partners (CPP) and Colorado Health Medical Group (CHMG) • Columbine network for chiropractic • Cofinity providers are in network for mental health services only See online directory for a complete list of current providers: **www.denverhealthmedicalplan.org/**	• Utilize Denver Health physicians and services • University of Colorado Hospital and Children's Hospital Colorado providers and facilities including Colorado Pediatric Partners (CPP) and Colorado Health Medical Group (CHMG) • Cofinity providers and facilities • Columbine network for chiropractic See online directory for a complete list of current providers: **www.denverhealthmedicalplan.org/**
Lowest copays	Higher copays	Within the Cofinity Network, slightly higher copays for physician office visits and specialty visits.
No deductibles	$100 per member, or $200 per family. All individual deductible amounts will count toward the family deductible. An individual will not have to pay more than the individual deductible amount.	Within Cofinity Network Deductible for certain services.
No coinsurance	No coinsurance for services	Within Cofinity Network, 20% coinsurance for diagnostic and hospital services

It is important for you to carefully review all the plan literature and other information. For additional information on the medical plans, visit the Managed Care site on the Pulse.

Dependent Information

It is very important that your dependent information be kept up-to-date with the HR Employee Benefits Center. It is your responsibility to notify the Benefits Center within 31 days of a child becoming ineligible for coverage, obtaining other coverage, or aging out of the plan. When the Benefits Center is notified on time, children aging out of the plan may receive a COBRA notice explaining their right to buy back their health care for up to a maximum of 36 months. Failure to notify the Benefits Center and continuing to use insurance for ineligible dependents is considered insurance fraud. See page 10 for dependent eligibility.

2019 Employee Medical Premiums — Per Pay Period

24 of 26 Bi-Weekly Paychecks

	DHHA Medical Care HMO		HIGHPOINT HMO		HIGHPOINT POINT OF SERVICE	
	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**
Employee Only	$33.68	$89.81	$65.65	$122.97	$88.97	$145.73
Employee + Spouse	$71.52	$190.72	$139.41	$262.39	$188.33	$308.50
Employee + Child(ren)	$60.03	$160.07	$117.01	$220.23	$158.91	$260.31
Employee + Family	$93.33	$264.89	$193.63	$364.44	$257.24	$421.38

* 0.75, 0.8, 0.9 and 1.0 FTEs are considered Full-Time for Benefits.
** 0.5 to 0.74 FTEs are considered Part-Time for Benefits.

Waiving Medical Coverage

If you are enrolled in a Denver Health medical plan and would like to cancel/waive coverage, you will need to show proof of other health insurance if your FTE is 0.75 or higher. Proof of other coverage must be received by the last day of open enrollment, October 31, 2018 or the coverage you had during 2018 will remain in effect for 2019.

Medical Plan Comparison

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			HighPoint Denver	Cofinity
Covered Providers	Denver Health and Hospital Authority, Columbine network for chiropractic Cofinity providers are in-network for outpatient mental health services only.	Denver Health and Hospital Authority, University of Colorado Hospital and Children's Hospital Colorado providers and facilities including Colorado Pediatric Partners (CPP) and Colorado Health Medical Group (CHMG) Columbine network for chiropractic	Denver Health and Hospital Authority, University of Colorado Hospital and Children's Hospital Colorado providers and facilities including Colorado Pediatric Partners (CPP) and Colorado Health Medical Group (CHMG) Columbine network for chiropractic	Cofinity providers and facilities, including Columbine network for chiropractic
	See online provider directory for a complete list at **www.denverhealthmedicalplan.org**			
Deductible and Maximums				
Annual Deductible	No deductible applies	$100 per member/ $200 per family All individual deductible amounts will count toward the family deductible. An individual will not have to pay more than the individual deductible amount.	No deductible applies	$500 per member/ $1,000 per family All individual deductible amounts will count toward the family deductible; an individual will not have to pay more than the individual deductible amount.
Out-of-Pocket Maximums	$4,350 per individual/ $8,700 per family Since these plans utilize copays for services, it is rare that these out-of-pocket maximums will be reached.	$5,000 per individual/ $10,000 per family Since these plans utilize copays for services, it is rare that these out-of- pocket maximums will be reached.	$5,000 per individual/ $10,000 per family Since these plans utilize copays for services, it is rare that these out-of- pocket maximums will be reached.	$5,000 per individual/ $10,000 per family Out-of-pocket maximums include annual deductible, coinsurance, and copays. It does not include premiums. All individual deductible amounts will count toward the family deductible; an individual will not have to pay more than the individual deductible amount.
Lifetime Maximum	No lifetime maximum			
Coinsurance / Copays				
Medical Office Visits – Personal Providers Family Medicine, Internal, Pediatrics	$25 copay per visit	$35 copay per visit	$25 copay per visit	$30 copay
	Three PCP visits per calendar year at $0 cost sharing at Denver Health facilities only			
Medical Office Visits – Specialist	$30 copay	$40 copay	$30 copay	$40 copay Deductible and coinsurance do not apply.
Preventive Services Children and Adults	No copayment (100% covered). This applies to all preventative services with an A or B recommendation from the U.S. Preventative Services Task Force (USPSTF) on our website at **www.denverhealthmedicalplan.org**			

Medical Plan Comparison *continued*

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			HighPoint Denver	Cofinity
Coinsurance / Copays				
Maternity Prenatal Care	$0 copay per visit	$0 copay per visit	$0 copay per visit	$0 copay per visit
Maternity Delivery, Inpatient and Well Baby Care	$200 copay per admission	$300 copay per admission	$200 copay per admission	Deductible and 20% coinsurance apply
Ambulance/Emergency Transport	$150 copay Covers out-of-network	$150 copay Covers out-of-network	$150 copay Covers out-of-network	$150 copay Covers out-of-network
Urgent Care	$50 copay Covers out-of-network	$50 copay Covers out-of-network	$50 copay Covers out-of-network	$50 copay Covers out-of-network
DispatchHealth	$50 copay	$50 copay	$50 copay	N/A
Emergency Care	$150 copay Covers out-of-network	$150 copay Covers out-of-network	$150 copay Covers out-of-network	$150 copay Covers out-of-network
Inpatient Hospital Maximum on surgical treatment of morbid obesity of once per lifetime.	$400 copay	$600 copay	$400 copay	Deductible and 20% coinsurance apply
	Applies to medical/mental health/ transplant admissions			
Outpatient/Ambulatory Surgery	$200 copay	$400 copay	$200 copay	Deductible and 20% coinsurance apply
Diagnostic Laboratory & Radiology				
Lab,	$0 copay	$0 copay	$0 copay	Deductible and 20% coinsurance apply
X-Ray and CT	$0 copay	$0 copay	$0 copay	Deductible and 20% coinsurance apply
MRI	$150 copay	$250 copay	$150 copay	$250 copay
PET Scans	$150 copay	$150 copay	$150 copay	$150 copay
Other Diagnostic & Therapeutic Services				
Sleep Study	$150 copay per test	$150 copay per test	$150 copay per test	$250 copay per visit
Radiation Therapy	$10 copay per visit	$10 copay per visit	$10 copay per visit	$10 copay per visit
Infusion Therapy Includes Chemo	$10 copay per visit	$10 copay per visit	$10 copay per visit	$35 copay per visit
Injections	$10 copay per visit (Immunizations, allergy shots, or any other injections given by a nurse are a $0 copay.)	$10 copay per visit (Immunizations, allergy shots, or any other injections given by a nurse are a $0 copay.)	$10 copay per visit (Immunizations, allergy shots, or any other injections given by a nurse are a $0 copay.)	$10 copay per visit (Immunizations, allergy shots, or any other injections given by a nurse are a $0 copay.)
Renal Dialysis	Covered at 100%	Covered at 100%	Covered at 100%	Deductible and 20% coinsurance apply

Medical Plan Comparison *continued*

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			HighPoint Denver	Cofinity
Therapy				
Physical, Occupational & Speech Therapy Rehabilitative & Habilitative	$10 copay	$20 copay	$10 copay	Deductible and 20% coinsurance apply
	Limit of 20 visits of each therapy per calendar year.			
Pulmonary Rehabilitation & Cardiac Rehabilitation Therapies	$10 copay per visit	$20 copay per visit	$10 copay per visit	Deductible and 20% coinsurance apply
	Limit of 20 visits of each therapy per calendar year.			
Behavioral Health, Mental Health Care and Substance Abuse				
Inpatient	$400 copay	$600 copay	$400 copay	Deductible and 20% coinsurance apply
Outpatient	$10 copay per visit at Denver Health If using a Cofinity provider, $25 copay per visit applies	$35 copay per visit If using a Denver Health facility, $10 copay will apply.	$25 copay per visit If using a Denver Health facility, $10 copay will apply.	$30 copay
Prescription Drug Copays*				
Denver Health Pharmacy 30-day supply	$4 discount $15 preferred generic $25 non-preferred generic		$40 preferred brand $50 non-preferred brand $60 specialty	
DHHA Pharmacies or DHHA Deliver-by-Mail 90-day supply	$8 discount $30 preferred generic $50 non-preferred generic		$80 preferred brand $100 non-preferred brand N/A specialty	
Non-DHHA Pharmacy 30-day supply	$8 discount $30 preferred generic $50 non-preferred generic		$80 preferred brand $100 non-preferred brand $120 specialty	
Non-DHHA Pharmacy 90-day supply	$16 discount $60 preferred generic $100 non-preferred generic		$160 preferred brand $200 non-preferred brand N/A specialty	
	*For drugs on our approved list, call Managed Care Member Services at 303-602-2100.			
Other				
Durable Medical Equipment (DME)	20% coinsurance applies			
Chiropractic Care	$20 copay per visit at Columbine Chiropractic only Maximum of 20 visits per calendar year			
Vision Care				
Routine Eye Exams	$30 copay per visit for routine eye exams	$40 copay per visit for routine eye exams	$30 copay per visit for routine eye exams	$40 copay per visit for routine eye exams
	Deductible and coinsurance waived. Limit of one routine eye exam every 24 months. Self-referral allowed in-network.			
Eyewear	Plan pays up to $350 one time per 24 month period for prescription eyewear. Only one claim can be submitted in a 24 month period, i.e. if you are using the benefit for contacts, you may want to wait until you have accumulated $350 in charges before submitting a claim in order to use full benefit. $200 toward Lasik surgery once per lifetime. This benefit can be used at any time regardless of whether or not the $350/24 month benefit has been used.			

Medical Plan Comparison *continued*

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			HighPoint Denver	Cofinity
Hearing Aids				
Adults	Medically-necessary hearing aids prescribed by a DHMP Medical Care Network provider are covered every five years in-network. For adults aged 18 and older, there is a $1,500 benefit maximum every 5 years. Charges exceeding the maximum are the responsibility of the member. Cochlear implants are covered for adults. The device is covered at 100%; applicable inpatient/outpatient surgery charges apply.			
Children	Children younger than 18 are covered at 100%; no maximum benefit applies. Hearing screens and fittings for hearing aids are covered under office visits and the applicable copayment applies. Hearing aids no longer apply to the annual DME limit. Cochlear implants are covered for children. The device is covered at 100%; applicable inpatient/outpatient surgery charges apply.			
Home Care				
Home Health Care	No copay (100% covered) for prescribed medically necessary skilled home health services			Deductible, then 100% covered for prescribed medically necessary skilled home health services
Hospice Care	No copay (100% covered)			Deductible, then 100% covered
Skilled Nursing Facility	No copay (100% covered) Maximum benefit is 100 days per calendar year at authorized facility			Deductible, then 100% covered. Maximum benefit is 100 days per calendar year at authorized facility
Dental				
Dental Care	Not Covered			

Prior authorization may be required for some services. Please refer to the prior authorization list, which can be found on our website at **www.denverhealthmedicalplan.org/prior-authorization-list**. For questions about prior authorization, please call Member Services at **303-602-2100** or toll-free at **1-800-700-8140** (TTY/TDD users should call 711).

For additional information regarding the DH Medical Plans, call Managed Care Customer Service at **303-602-2100** or visit **www.denverhealthmedicalplan.org/**.

Dental Plans

Delta Dental

Denver Health offers three dental plans through Delta Dental of Colorado. Remember, the Delta PPO Premier Plan has additional discounts that you can choose to use at a PPO Dental Provider for your dental care. A brief comparison chart follows, and pretax per-pay-period deductions follow on the next page.

Delta Dental Providers

Delta Dental is the most comprehensive provider network in the Denver Metro Area. Here are three dental options:

- **Delta Dental EPO 3C Basic, Group #7155:** This plan is designed to maintain your overall good dental health, while providing coverage for fillings and other restorative needs, as well as orthodontics. This plan is a copay system. This plan utilizes dentists from the EPO/PPO Provider list. You can also search for dentists at **www.deltadentalco.com**.
- **Delta Dental EPO 1B, Group #0587:** This plan provides more comprehensive coverage for your restorative and orthodontic needs. This plan is a copay system. This plan also utilizes the EPO/PPO Provider list. You can search for dentists at **www.deltadentalco.com**.
- **Delta Dental PPO/Premier, Group #7967:** This plan is a traditional indemnity plan designed to offer you the most flexibility. Utilizing deductibles and coinsurances, and without the restrictions of a provider list, you can go to any dentist you want. Premier members can lower their dental costs when they choose to utilize a PPO Provider. Adult orthodontic coverage is not offered under Delta PPO Premier Plan. **This is the only option that currently covers dental implants.**

Dental Care

One of the primary ways to ensure that your dental premiums remain stable is for participants to take advantage of dental preventative cleanings and exams under the dental plans. Poor oral health leads to other expensive dental and health procedures like tooth decay, gum disease, heart disease, heart attacks, strokes, and respiratory disease.

Note: Employee Dental Premiums are not increasing for 2019

2019 Employee Dental Premiums — Per Pay Period

24 of 26 Bi-Weekly Paychecks

	Delta Dental EPO 3C Basic		Delta Dental EPO 1B		Delta Dental PPO/Premier	
	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**
Employee Only	$0.92	$3.68	$4.43	$8.06	$14.46	$17.92
Employee + 1	$2.03	$7.51	$8.20	$14.20	$26.24	$32.44
Employee + 2 or more	$3.33	$11.64	$15.49	$24.14	$39.50	$48.65

* 0.75, 0.8, 0.9 and 1.0 FTEs are considered Full-Time for Benefits.
** 0.5 to 0.74 FTEs are considered Part-Time for Benefits.

Dental Plan Comparison

Service/Procedure Guide	Delta EPO 3C Basic Group # 7155	Delta EPO 1B Group # 0587	Delta PPO/Premier Group # 7967
Dentist Choice	EPO/PPO List	EPO/PPO List	No Restrictions
Services			
Bitewing, single film (D0270)	$0 copay	$0 copay	90% covered
Cleaning (D110 & D1120)	$0 copay	$0 copay	90% covered
Amalgam Filling (D2150)	$44 copay	$28 copay	70% covered after $25 deductible
Crown/Porcelain (D2750)	$431 copay	$284 copay	60% covered after $25 deductible
Implants and Teeth on Implants	Not covered	Not covered	60% covered after $25 deductible
Orthodontic Treatment			
Children (D8080)	50% of charges up to $2,000 maximum		50% covered, maximum lifetime benefit of $1,100
Adult (D8090)	50% of charges up to $2,000 maximum		Not covered
Deductibles and Maximums			
Annual Deductible	None	None	$25
Annual Maximum Benefit	$2,000*	$2,000*	$1,100*

*Annual maximum does not include orthodontic benefit.

Voluntary Vision Plan

VSP

2019 Vision Premiums

Vision Plan	
COVERAGE	BI-MONTHLY PAYMENTS
Single	$3.24
Two Party	$6.48
Family	$10.44

	Your Coverage with a VSP Provider		
	DESCRIPTION	COPAY	FREQUENCY
Well Vision Exam	Focuses on your eyes and overall wellness	$15	Every calendar year
Prescription Glasses		$15	See frame and lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • $80 allowance at Costco • 20% savings on the amount over your allowance	Included in prescription glasses	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate Lenses for dependent children	Included in prescription glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses Average savings of 20-25% on other lens enhancements	$0	Every calendar year
Contacts (instead of Glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal Screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.	$20	As needed

Extra Savings Available Through Vision Plan

Glasses and Sunglasses:

- Extra $20 to spend on featured frame brands. Go to **www.vsp.com** for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements from any VSP provider within 12 months of your last Well Vision exam.

Retinal Screening

No more than a $39 copay on routine retinal screening as an enhancement to a WellVision exam.

Laser Vision Correction

Average 15% off the regular price or 5% off the promotional price. Discounts are only available from contracted facilities.

Your Coverage With Out-Of-Network Providers	
VISIT VSP.COM FOR DETAILS, IF YOU PLAN TO SEE A PROVIDER OTHER THAN A VSP NETWORK PROVIDER.	
Exam	Up to $65
Frame	Up to $77
Single Vision Lenses	Up to $31
Lined Bifocal Lenses	Up to $50
Lined Trifocal Lenses	Up to $65
Progressive Lenses	Up to $50
Contacts	Up to $35

Flexible Spending Accounts

WageWorks

Benefit-eligible employees may choose to participate in Flexible Spending Accounts (FSA). Denver Health has provided these accounts to assist with budgeting out-of-pocket medical and dependent care expenses. Through the FSA plans, employees can direct part of their paycheck into these special accounts on a pretax basis.

Note: Re-enrollment is required every year.

A Flexible Spending Account offers the following benefits:

- Reduce your state and federal taxes, because FSA contributions are untaxed at the time of withdrawal. Taxable income may be decreased, while spendable income is increased.
- The ability to budget for health care and dependent care expenses that are not paid for by other benefit programs in advance for the following year. This account should be carefully managed, because any unused money left in the account at the end of the plan year will be lost.
- Use pretax dollars to pay for uninsured usual and customary health care expenses (i.e. eyeglasses, deductibles, copayments, coinsurance, over-the-counter supplies, etc.), and usual and customary dependent care expenses (day care costs incurred while you work).
- The convenience of setting aside money through regular pretax payroll deduction.

Health Care Flexible Spending Account

The Health Care Flexible Spending Account allows employees to set aside between $240 and $2,650 pretax dollars per calendar year for reimbursement for some usual and customary out-of-pocket health care costs of the employee, spouse and children. This money can be used for deductibles, copays, coinsurance, over-the-counter medical supplies, and uncovered medical, dental and vision expenses for you, your spouse and children.

Under Healthcare Reform, the maximum dollar amount that can be reimbursed for Healthcare is $2,650.

Remember that over-the-counter **drugs and medication** are no longer eligible reimbursable expenses under FSA, except with a physician's prescription. However, over-the-counter **medical supplies** are still a reimbursable expense.

Reimbursable Over-The-Counter Medical Supplies			
NO PRESCRIPTION NEEDED			
Bandages/First Aid Dressing	Contact Lens Solution	Heating Pads	Orthopedic Aids
Birth Control Products	Denture Products	Hot, Cold & Steam Packs	Pregnancy & Fertility Kits
Blood Pressure Kits	Diabetes Testing Supplies	Incontinence Products	Splints, Supports, & Braces
Canes & Walkers	Durable Medical Equipment	Insulin	Thermometers
Contact Lenses	Hearing Aid Batteries	Nebulizers	Wheelchairs & Accessories

Dependent Care Flexible Spending Account (Day Care Expenses)

The Dependent Care Flexible Spending Account allows employees to set aside between $240 and $5,000 per calendar year on a pretax basis for reimbursement for dependent care (day care) costs. This money can be used for day care expenses for children under the age of 13, or an elderly parent who requires supervision while you work.

Note: If an employee makes less than $43,000 a year, the federal child care credit may be more advantageous. Consult a tax advisor to determine which plan works best.

Flexible Spending Account Plan Year Extended 2½ Months

Employees with leftover funds from the 2018 plan year, have until March 15, 2019 to incur expenses to apply toward those leftover funds.

Deadline for filing all expense reimbursement claims for the 2018 plan year is April 15, 2019.

Flexible Spending Account Re-enrollment, Minimums and Maximums

If you participate in a Flexible Spending Account this year and you would like to participate next year, you will need to re-enroll using the Lawson Open Enrollment Portal.

You can re-enroll just by entering either your per-pay-period contribution (remember, you contribute from 24 of your 26 paychecks), or by entering your total annual contribution through the Lawson Portal. If you do not enter an amount in the flexible spending re-enrollment section, it will be assumed that you do not wish to participate in an FSA during 2019, and your contributions will stop after the December 18, 2018 paycheck.

2018 FSA Minimum and Maximum Dollar Amounts (24 Pay Periods)				
	BI-WEEKLY MINIMUM	BI-WEEKLY MAXIMUM	ANNUAL MINIMUM	ANNUAL MAXIMUM
Type of FSA				
Health Care	$10	$108.33	$240	$2,650
Dependent Care	$10	$208.33	$240	$5,000

Important: Employees should always keep their receipts submitted for FSA reimbursement should you be audited by the IRS. The IRS will want to see these receipts in the event of an audit.

Retirement Plans

401(a) Defined Contribution Plan and Trust (Social Security Replacement Plan)

Denver Health employees have a special retirement plan available that most employers are not able to offer. While working for Denver Health, all employees contribute 6.2% of each paycheck (up to IRS limits) to an individual 401(a) plan instead of paying into Social Security. In addition, Denver Health contributes a total of 3% (up to Social Security limits) of each paycheck on the employee's behalf. This is a mandatory defined plan in which employee contributions cannot be stopped or changed.

401(a) Enhanced Retirement Provision

In addition to the 3% contribution for the Social Security Replacement Plan, Denver Health contributes an additional 3% (up to IRS limits) on behalf of all benefit-eligible employees, except DERP participants. These contributions are 100% vested after 3 years of employment with DH for employees hired after August 22, 2015. Employees hired before August 22, 2015 are already fully vested in this retirement plan.

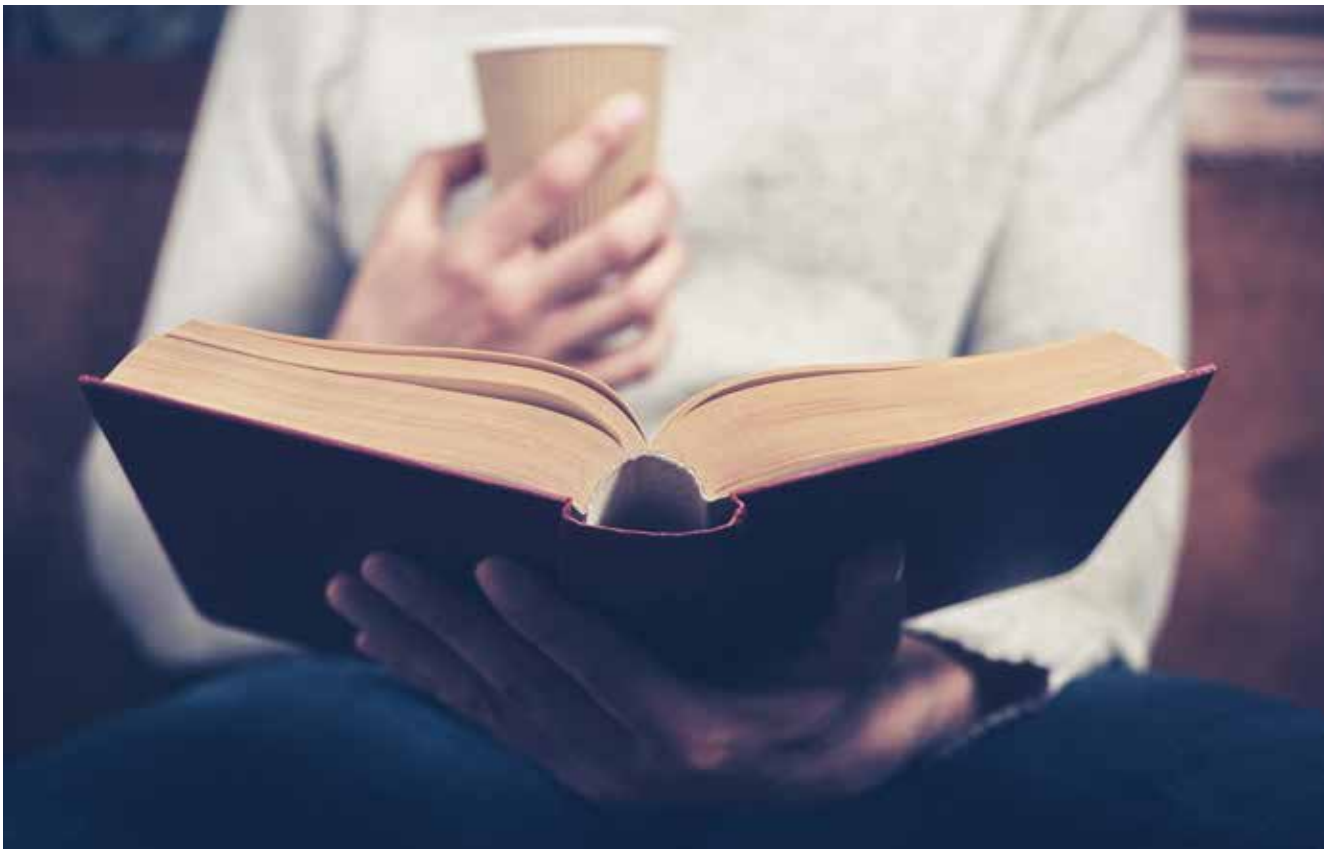
457(b) Deferred Compensation Plan (Voluntary Retirement Savings Plan)

Denver Health offers this voluntary retirement plan that allows employees to invest more pretax or after-tax (Roth) dollars up to $18,500. Employees age 50 or older can invest up to $24,500. Denver Health will match dollar-for-dollar up to 3.5% of the employee's eligible salary. All employees are auto-enrolled in this plan with contributions set at 3.5%. Employees have the option of increasing, reducing, or opting out of this auto-enrollment. DH's matching contribution is also subject to the 3 year vesting schedule for employees hired after August 22, 2015. Other percentage limits of compensation will apply. A variety of Fidelity funds are available to meet your investment needs.

Fidelity Investments is Denver Health's retirement plan vendor. Employees can direct their investments either online at **https://plan.fidelity.com/denverhealth** or through Fidelity's call center at **800-343-0860**. Employees can also establish or update their beneficiaries at Fidelity's call center or website.

Tuition Reimbursement

Denver Health recognizes the value and importance of an educated workforce. Employees who have been employed for more than 90 days and are working toward a GED or High School Diploma may be eligible to apply for tuition reimbursement. Employees taking college-level courses or working toward a degree that will enhance their performance or provide career advancement at Denver Health may be eligible to apply for tuition reimbursement.



Denver Health provides the following in the Tuition Reimbursement program. For additional information, visit the Benefits Homepage of the Pulse and click on the *Tuition Reimbursement* link.

FTE	Reimbursement Level Based on FTE	2018 Annual Dollar Amount up to Bachelor Degree	2018 Annual Dollar Amount for Master/PhD Programs
1.0	100%	$2,500	$3,500
0.9	90%	$2,250	$3,150
0.8	80%	$2,000	$2,800
0.7	70%	$1,750	$2,450
0.6	60%	$1,500	$2,100
0.5	50%	$1,250	$1,750

Life Insurance and Accidental Death & Dismemberment (AD&D)

Unum

Unum provides Denver Health with our Group and Voluntary Life & AD&D. Here are some highlights:

Basic Life Insurance and AD&D

Basic Life insurance and AD&D Denver Health provides all benefit-eligible employees with Basic Life insurance and AD&D coverage. All eligible employees will be covered at one times their annual salary. There is a minimum policy value of $50,000 for those employees earning less than $50,000 a year.

The maximum policy value for this plan is $500,000 for all employees, except physicians and executives maximum value is $1,000,000. This is a double indemnity policy that will pay double the policy's value in the event that the insured dies as a result of an accident.

This plan provides a living benefit option if you are diagnosed with a terminal illness expected to result in your death in less than 12 months. You also have the option to convert your coverage to an individual policy if you leave Denver Health.

Unum also offers free access to Will Preparation Services and Beneficiary Support Services through Health Advocate, and free Travel Assistance Services through Assist America.

FTE Status	Basic Life (per $1,000)
1.0	$0.00
0.9	$0.00
0.8	$0.00
0.7	$0.04
0.6	$0.05
0.5	$0.06

Note: If an employee is working half-time (0.5 FTE) and earning $27,000 per year, the per pay period Life insurance deduction would be calculated as ($27,000/1000) X $0.06 = $1.62 per pay period.

Voluntary Life Insurance and AD&D

As a new hire employee within 31 days, you have the opportunity to apply for this coverage up to a guaranteed amount of $250,000 for the employee and $50,000 for his/her spouse without having to answer medical questions. Employees can apply at any time during the year for additional Life insurance and/or AD&D coverage for themselves; their spouse including common-law, domestic partner; and children under the age of 26. Voluntary employee coverage may be purchased up to the maximum amount of $500,000 and is subject to underwriting.

Disability Plans

Both Short-Term Disability (STD) and Long-Term Disability (LTD) coverage are designed to provide salary continuation during a period when the employee is determined to be medically unable to perform their duties due to a non-work related injury, illness, or pregnancy.

STD and LTD take effect on the first of the month following six months of employment. Denver Health provides both STD and LTD coverage free of charge to all benefit-eligible employees who work at least 20 hours per week (FTE 0.5 or greater) on a regular basis.

Short-Term Disability (STD)

In the event an employee is medically unable to work due to a non-work related injury or illness, this benefit may pay up to 60% of the employee's weekly base compensation with a weekly maximum of $1,750.

For qualified employees, benefits begin paying on the eighth day that the employee is out of work. Employees will receive a portion of lost wages up to a maximum of 26 weeks within a 36-month period. After 26 weeks, Denver Health provides a LTD plan for eligible employees.

- STD is used concurrently with Family Medical Leave if eligible.
- STD can be enhanced by being supplemented with PTO.
- STD is a taxable benefit paid to the employee through payroll like a regular paycheck.
- Denver Health pays for 100% of the core cost of this benefit.

STD Buy-Up Option

Benefit-eligible employees have the option to purchase additional STD coverage (buy-up) that would replace up to 70% of your covered weekly earnings up to a maximum weekly amount of $3,800. Employees would pay for the cost of the buy-up through payroll deduction.

Long-Term Disability (LTD) — Unum

Long-Term Disability insurance helps replace a portion of your income if you're sick or injured and unable to work due to a non-work related injury or illness. If an employee's disability extends beyond the 26 weeks of STD, then LTD may be available. The plan replaces up to 60% of your covered monthly earnings to a maximum monthly benefit of $15,000 provided at no cost to you by Denver Health. LTD benefits begin after you have been totally disabled for 180 days. This 180 day period is known as the elimination period. Your monthly LTD benefit may be reduced by the amount of other income benefits you receive, but it will not be less than $100.

LTD Buy-Up Option

You have the option to purchase additional LTD insurance (buy-up) that would replace up to 70% of your covered monthly earnings to the same maximum monthly benefit of $15,000. You pay for the cost of the additional insurance.

Voluntary Benefits

Group Legal Plan

Hyatt Premier Legal Service Plan provides employees with access to attorneys for legal matters such as wills, estate planning, real estate matters, family law, defense of civil lawsuits and debt defense. A $7.50 per pay period deduction (24 of 26 bi-weekly paychecks) covers the employee and their eligible dependents.

MetLife Home and Auto

Employees can get auto, homeowners, renters, boat or RV insurance through payroll deduction. Contact MetLife at **800-438-6381** for a premium quote or to enroll. Free auto quotes are available at **autohome.metlife.com**.

Denver Community Credit Union

Low interest loans, credit cards, checking accounts, savings accounts, Christmas Club accounts, IRAs and other services are available. For additional information, call **303-573-1170** or visit **www.denvercommunity.coop**.

PerkSpot

PerkSpot is a one-stop-shop for exclusive discounts at many of your favorite national and local merchants! You can use PerkSpot to find hundreds of deals on everything from household essentials to once-in-a-lifetime vacations. PerkSpot is mobile-optimized, so you can access it at home, from work, or on the go! The best part is that it's no cost to you. Perkspot can be found by following the links on the Pulse, or by going to **http://denverhealth.perkspot.com**.

Time Away From Work

Paid Time Off (PTO)

Denver Health recognizes the need for employees to have time away from work and provides paid time off (PTO) for eligible employees. PTO accrual is pro-rated based on the actual number of hours worked in a pay period to a maximum of 80 hours.

PTO is flexible paid time off from work that can be used for such needs as vacation, personal or family illness, doctor's appointments, and other activities of the employee's choice.

Paid Time Off (PTO) Accrual Rates for 1.0 FTE				
YEARS OF SERVICE	PER PAY PERIOD	ANNUAL ACCRUAL	MAXIMUM CARRY OVER HOURS	MAXIMUM HOURS
0 to 4 years	0 to 4 years	160 hours or 20 days	152 hours	312 hours
5 to 9 years	5 to 9 years	184 hours or 23 days	160 hours	344 hours
10 to 14 years	10 to 14 years	208 hours or 26 days	176 hours	384 hours
15 plus years	15 plus years	232 hours or 29 days	184 hours	416 hours

Note: PTO hours over the "Maximum Carry Over Hours" will automatically be paid out in October of each year.
Note: PTO accruals are pro-rated based on employee's FTE status.

NEW Bereavement Leave

In the event of the death of an immediate family member, employees will be given three consecutive paid leave days. An immediate family member is a spouse, child, parent, or sibling. Each employee is entitled to up to one Bereavement Leave per year. Bereavement leave does not accrue and does not add to an employee's PTO balance.

2019 DHHA Observed Holidays

2019 DHHA Observed Holidays	
New Year's Day (observed)	Tuesday, January 1
Martin Luther King Day	Monday, January 21
Memorial Day	Monday, May 27
Independence Day	Thursday, July 4
Labor Day	Monday, September 2
Thanksgiving Day	Thursday, November 28
Christmas Day	Wednesday, December 25

Denver Health Well-Being

Physical, Financial, Mental, Social

Denver Health cares about YOU! The vision of the program is to create a thriving organizational culture of workplace well-being at Denver Health.

As an employee at Denver Health you have access to a comprehensive well-being program. Our "keys to well-being" support the whole employee by focusing on physical, social, mental, and financial well-being programs.

- Take advantage of the many well-being programs during the year to include health behavior challenges, fitness center discounts, onsite employee fitness center, wellness seminars, and much more!
- We must take care of ourselves so we can always take care of others.
- Denver Health supports employees' efforts to become and remain healthy. Human Resources offers incentives to employees who commit to healthy lifestyles.
- Our Healthy Hospital efforts aim to provide team members with a supportive and healthy workplace environment so that we can in turn be supportive and resilient for the patients and families we serve.

Health Advocate Employee Assistance Program

- Benefits for you, your spouse or domestic partner, dependent children, parents, and parents-in-laws, to help find resources to solve personal problems.
  - These problems may include issues with family, childcare, alcohol, drugs, emotions, stress, and legal or financial questions.
- Face-to-face sessions
- Confidential
- Available 24 hours a day, 7 days a week
- Call **866-799-2728** or go to **HealthAdvocate.com/members**. You can use the Health Advocate mobile app.

WorkLife Partnership: Better Work. Better Life.

- Denver Health has partnered with WorkLife Partnership to provide you with resources and assistance to help overcome work-life challenges, so you can focus on being the best employee you can be. WorkLife services are always free and always confidential. WorkLife is your access to resources to help you and family members navigate work-life issues.
  - Visit **www.worklifecolorado.org**
  - Email **denverhealth@worklifecolorado.org**
  - Text **DENVERHEALTHNAV** to **555888** to connect to a Navigator
  - **303-298-1625**

myStrength

From resiliency to well-being myStrength's digital behavioral solution empower individuals with engaging, clinically-proven resources. myStrength's suite of comprehensive digital self-help tools includes guided programs for depression, anxiety, substance use disorder, chronic pain, and stress management resources.

Sign Up Today:

- Visit **www.mystrength.com** and click *Sign Up*.
- Enter Access Code: **DHHAemployees**
- Complete the myStrength sign-up process and personal profile.

Denver Health Employee Fitness Center

The fitness center is located on the fourth floor of 601 Broadway. A Denver Health ID badge is required to enter the building and fitness center.

- The fitness center is open 24 hours a day, 7 days a week.
- Membership is available to all Denver Health and Hospital Authority and CSA employees, contract security personnel, physician residents and Denver Health volunteers.
- Membership dues are $7.50 per pay period.
- Fitness classes are included in membership!

Healthy Hospital Initiative

- We are committed to offering healthy options and a wide variety of foods to our patients, team members and visitors, as well as providing simple labeling and nutrition information to help guide healthy choices.
- As part of our Healthy Hospital Initiative and the overall mission of Denver Health, we are committed to providing a healthy environment and being a role model for patients and families, visitors, and other institutions. In addition, we believe we have a responsibility to model and advocate healthy behaviors within our organization and throughout the community. We have proudly phased out the sale of sugar-sweetened beverages, and only sell healthier drinks.

Important Notices

Women's Health and Cancer Rights Act Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your plan administrator at 303-602-7000.

Health Care Reform

To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment based health coverage offered by your employer.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution as well as your employee contribution to employer-offered coverage- is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description. The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **http://connectforhealthco.com/** or **https://www.healthcare.gov/** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Medicaid and The Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from Denver Health, the state of Colorado may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **healthcare.gov.**

If you or your dependents are already enrolled in Medicaid or CHIP, contact the State Medicaid or CHIP office to find out if premium assistance is available.

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 for either of these programs, contact the State Medicaid or CHIP office or dial 1-877-KIDS NOW or **insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow

you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at **askebsa.dol.gov** or call 866-444-EBSA (3272).

Colorado Medicaid and CHIP contact info:

Medicaid Website: colorado.gov/hcpf

Medicaid Phone (In state): 800.866.3513

Medicaid Phone (Out of state): 800.221.3943

Colorado Children's Health Coverage Programs:
800.221.3943

Important Notice to Employees from DENVER HEALTH AND HOSPITAL AUTHORITY About Creditable Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the Denver Health and Hospital Authority medical plan are expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2019. This is known as "creditable coverage."

Why this is important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2019 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription drug plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. You should keep this notice with your important records.

If you or your family members aren't currently covered by Medicare and won't become covered by Medicare in the next 12 months, this notice doesn't apply to you.

Please read the notice below carefully. It has information about prescription drug coverage with Denver Health and Hospital Authority and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

Notice of Creditable Coverage

You may have heard about Medicare's prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for a higher monthly premium.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by one of the Denver Health and Hospital Authority prescription drug plans, you'll be interested to know that the prescription drug coverage under the plans is, on average, at least as good as standard Medicare prescription drug coverage for 2018. This is called creditable coverage. Coverage under one of these plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare and later decide to enroll in a Medicare prescription drug plan.

- DHHA Medical Care HMO
- HighPoint HMO
- HighPoint Point of Service Plan

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your employer coverage. In this case, the Denver Health and Hospital Authority plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop Denver Health and Hospital Authority coverage, Medicare will be your only payer. You can re-enroll in the employer plan at annual enrollment or if you have a special enrollment event for the Denver Health and Hospital Authority plan, assuming you remain eligible.

You should know that if you waive or leave coverage with Denver Health and Hospital Authority and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as before the next period you can enroll in Medicare prescription drug coverage, if this Denver Health and Hospital Authority coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here's how to get more information about Medicare prescription drug plans:

- **Visit www.medicare.gov** for personalized help.
- Call your State Health Insurance Assistance Program

(see a copy of the Medicare & You handbook for the telephone number).

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov** or call 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare prescription drug plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Denver Health and Hospital Authority
HR Benefits Department
601 Broadway – 5th Floor, MC 0115,Denver CO 80204
303-602-7000

General Notice of COBRA Continuation Coverage Rights

This notice is being provided to you at this time because you have recently become, or are about to become, covered under a group health plan being maintained by the Denver Health Medical Plan, otherwise known as the Plan. This notice generally explains group health insurance continuation coverage, when it may become available, and what you need to do to protect the right to receive it. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents.

Only one notice is being provided to all plan participants at this time, since based upon the information provided to the plan, all plan participants live at the same location. However, continuation coverage rights apply individually to a covered spouse and/or covered dependent children. So if there is a covered dependent whose legal residence is different, you must provide written notification to the plan administrator so a notice can be sent to them as well. Should you add additional dependent children in the future, notice to the covered employee and spouse at this time will be deemed notification to the newly covered dependent.

What Is Continuation Coverage - The right to group health insurance continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Should you lose your group health insurance in the future because of one of the below listed qualifying events, covered employees and covered family members (called qualified beneficiaries) will be offered the opportunity for a temporary extension of health coverage (called "Continuation Coverage) at group rates which you will be required to pay. This notice is intended to inform all plan participants, in a summary fashion only of your potential future options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time. Please take special note, however, of your notification obligations and procedures, which are highlighted in this notification.

Qualifying Events For Covered Employee - If you are the covered employee, you will become a qualified beneficiary and have the right to elect health plan continuation coverage if you lose your group health coverage because of a termination of your employment (for any reason other than gross misconduct on your part), or a reduction in your hours of employment (including military call-up).

Qualifying Events For Covered Spouse - If you are the covered spouse of an employee, you will become a qualified beneficiary and have the right to elect health plan continuation coverage for yourself if you lose health coverage because of any of the following reasons:

1. A termination of your spouse's employment for (any reason other than gross misconduct on the employee's part) or a reduction in your spouse's hours of employment (including military call-up);
2. The death of your spouse;
3. Divorce, or if applicable, legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare benefits (Part A, Part B, or both).

Under federal law, the term "spouse" includes a person of the opposite sex and the employee and spouse are married according to the state law in which they reside. While the group health plan may allow domestic partners and/or same sex marriage partners to be covered by the plan, if they lose group health insurance as a result of one of the above listed events, they will not be offered the opportunity to continue group health insurance as an individual qualified beneficiary.

Qualifying Events For Covered Dependent Children - If you are the covered dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself if you lose group health coverage because of any of the following reasons:

1. A voluntary or involuntary termination of the parent-employee's employment (for any reason other than gross misconduct on the employee's part) or a reduction in the parent-employee's hours of employment;
2. The death of the parent-employee;
3. Parent's divorce or, if applicable, legal separation;
4. The parent-employee becomes enrolled in Medicare benefits (Part A, Part B, or both); or
5. You cease to eligible for coverage as a "dependent child" under the terms of the plan.

Employer Notification Responsibilities: If the qualifying event is a termination of employment, reduction in hours, death or enrollment in Medicare benefits (Part A, Part B, or both), or if retiree coverage is provided, a commencement of a bankruptcy proceeding, the employer must notify the Plan Administrator of the qualifying event within a maximum period of 30 days. Once notified, the plan administrator will then notify you of your continuation coverage rights.

IMPORTANT EMPLOYEE/COVERED DEPENDENT NOTIFICATION RESPONSIBILITIES REGARDING DIVORCE, DEPENDENT CHILDREN CEASING TO BE DEPENDENTS

While the employer is responsible for certain qualifying events described above, under group health plan rules and COBRA law, the employee, spouse, or other family member has the responsibility to notify the plan administrator of a divorce, legal separation, or a dependent child losing dependent status under the plan. For a complete description on the plan eligibility rules regarding a spouse and/or children, please read your (summary plan description). To protect your continuation coverage rights in these two situations, this notification of a qualifying event must be made within 60 days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event.

You must provide this notice to COBRA Administrator. Procedures for making this proper and timely notice are listed below. Example:

1. Complete the COBRA Qualifying Event/Extension of Benefits notification form on Benefits web site.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event or physician certification.
4. Mail the notification form to the address listed on the form and document your mailing.
5. Call within 10 days to ensure the notification form has been received.

If this notification is not completed according to the outlined procedures and within the required 60 day notification period, the individual will be notified they have forfeited their group health insurance continuation coverage rights. **NO LATE NOTIFICATIONS WILL BE ACCEPTED!** In addition, keeping an individual covered by the health plan beyond what is allowed by the plan will be considered insurance fraud on the part of the employee.

How is continuation coverage provided? Once the COBRA administrator learns a qualifying event has occurred, the administrator will notify qualified beneficiaries of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights, so for example, a covered employee may elect group health insurance coverage on behalf of their spouse, and parents may elect on behalf of their children. More specific information regarding the maximum election period will be provided to the qualified beneficiary at the time of the qualifying event. NO LATE ELECTIONS WILL BE ACCEPTED. If a qualified beneficiary elects continuation coverage, they will be required to pay the entire cost for the group health insurance, plus a 2% administration fee. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length Of Continuation Coverage - 18 or 24 Months. If the event causing the loss of coverage is a voluntary termination or involuntary termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for a maximum period of 18 months. If you are a reservist and are called to active duty, each qualified beneficiary will have the opportunity to continue coverage for a maximum period of 24 months. Exception: If you are participating in a health flexible spending account at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.

In general, there are three ways in which the 18 or 24 month period of continuation coverage can be extended.

Social Security Disability Extension - The 18 or 24 months of continuation coverage can be extended for additional months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act. The disability would have to have started at some time prior to the date of the qualifying event or within the first 60 days of continuation coverage and must last until the end of the 18 or 24 month period of continuation coverage. It is the qualified beneficiary's responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination according to the below listed notification procedures within 60 days after the date of determination and before the original 18 or 24 months expire. **NO LATE NOTIFICATIONS WILL BE ACCEPTED!** Notice must be provided to COBRA Administrator.

1. Complete the enclosed COBRA Qualifying event notification form on Benefits web site.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the address listed on the form and document your mailing.
5. Call within 10 days to insure the notification form has been received.

Secondary Event Extension - Another extension of the 18 or above mentioned 29 month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement

(under Part A, Part B, or both), or a dependent child ceasing to be a dependent. A second event can only occur if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Continuation coverage will be extended to a maximum 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It will be the qualified beneficiary's responsibility to notify the plan administrator of a second event. Procedures for making proper and timely notice of a second event will be detailed in the election notice when a qualifying event occurs.

Special Medicare Entitlement Rule For Dependents Only - If the employee is entitled to Medicare benefits prior to the date of the original 18-month qualifying event, then the dependent qualified beneficiaries are eligible for the 18 months of continuation coverage, or 36 months measured from the date of the Medicare entitlement, whichever is greater. For example, if a covered employee becomes entitled to Medicare eight (8) months prior to the date on which employment terminates, the dependent qualified beneficiaries will be offered 28 months of continuation coverage (36 - 8 = 28). The covered employee, however, will only be offered 18 months.

Length Of Continuation Coverage - 36 Months. If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child, then each dependent qualified beneficiary will have the opportunity to continue coverage for a maximum 36 months from the date of the qualifying event. Under no circumstances will coverage be provided for longer than 36 months.

Eligibility, Premiums, And Potential Conversion Rights - A qualified beneficiary must have been actually covered by the plan on the day before the event to be eligible for continuation coverage. A qualified beneficiary will be required to pay the full premium equal to 100% plus a 2% administration charge. At the end of the 18, 24, 29, or 36 months of continuation coverage, a qualified beneficiary will be allowed to enroll in an individual conversion health. The law also provides that continuation coverage will end prior to the maximum continuation period for a variety of reasons. Should a qualifying event occur in the future, the election notice will detail these early termination reasons.

Notification Of Address Change - In order to protect your group health insurance continuation coverage rights and to insure all covered individuals receive information properly and efficiently, active employees are required to change their address on the LAWSON portal as soon as possible. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options. Address change should be done through your LAWSON portal.

Any Questions? - This notice is a summary of your potential future continuation coverage options only and not a description of your actual health plan or full COBRA rights. For any health plan questions, you should review the DHMP Member Handbook located at **www.denverhealthmedicalplan.com**. Should you have any continuation coverage questions regarding the information contained in this or any future notice, you should contact the parties listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's web site at **www.dol.gov/ebsa.**

Plan and Continuation Coverage Contact Information

Denver Health Hospital COBRA Administrator
601 Broadway – 5th Floor, MC 0115, Denver, CO 80204
Phone: 303-602-7000

Notice of Special Enrollment Rights for Health Plan Coverage

As you know, if you have declined enrollment in Denver Health and Hospital Authority health plan for you or your dependents (including your spouse) because of other health insurance coverage, you or your dependents may be able to enroll in some coverages under this plan without waiting for the next open enrollment period, provided that you request enrollment within 31 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 eligible dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Denver Health and Hospital Authority will also allow a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible, or
- Become eligible for a state's premium assistance program under Medicaid or CHIP.

For these enrollment opportunities, you will have 60 days – instead of 31 – from the date of the Medicaid/CHIP eligibility change to request enrollment in the Denver Health and Hospital Authority group health plan. Note that this new 60-day extension doesn't apply to enrollment opportunities other than due to the Medicaid/CHIP eligibility change.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Newborns' and Mothers' Health Protection Act Notice

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 303-602-7000.

ACA Section 1557 Notice, Statement and Taglines

For translated versions of the following ACA Section 1557 notices, please see the HHS website, here: https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

Discrimination is Against the Law

Denver Health and Hospital Authority complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age disability or sex. Denver Health and Hospital Authority does not exclude people or treat them differently because or race, color, national origin, age, disability or sex.

- Denver Health and Hospital Authority provides free aids and services to people with disabilities to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is no English, such as:
- Qualified interpreters
- Information written in other languages

If you need these services, contact
Denver Health and Hospital Authority
HR Benefits Department
601 Broadway – 5th Floor, MC 0115,
Denver CO 80204
303-602-7000

If you believe that Denver Health and Hospital Authority has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Denver Health and Hospital Authority

HR Benefits Department
601 Broadway – 5th Floor, MC 0115,
Denver CO 80204
303-602-7000

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, [Name and Title of Civil Rights Coordinator] is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically thru the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Rom 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 TDD)

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Notes

Important Contacts

Denver Health and Hospital Authority
HR Employee Benefits Center
601 Broadway – 5th Floor

Benefit Line: 303-602-7000
Fax: 303-602-7010
Email: Benefits@dhha.org
Mail Code 0115

Company	Phone Number	Website
Health Advocate (Advocacy and EAP)	866-799-2728	HealthAdvocate.com/members
Career Service Authority Benefits	720-913-5697	www.denvergov.org/csa
Cofinity (HighPoint POS Provider Network)		www.cofinity.net
Delta Dental of Colorado	303-741-9305	www.deltadentalco.com
Denver Community Credit Union	303-573-1170	www.denvercommunity.coop
DERP (Denver Employee Retirement Plan)	303-839-5419	www.derp.org
Denver Health Appointment Line	720-956-2227	
Denver Health Medical Plans	303-602-2100	www.denverhealthmedicalplan.org
Fidelity Investments – 401(a) & 457(b)	800-343-0860	www.fidelity.com/atwork
Hyatt Legal Plan	800-821-6400	www.legalplans.com
MetLife (Auto, Boat, Home, Renter Ins., etc.)	800-438-6381	www.metlife.com/mybenefits
Unum (Life, AD&D, LTD)	800-421-0344	www.unum.com
Short-Term Disability (HR LOA Center)	303-602-7007	LOAFMLProcess@dhha.org
Vision Service Plan (VSP)	800-877-7195	www.vsp.com
WageWorks (FSA's)	877-924-3967	www.wageworks.com
WorkLife Partnership of Colorado	303-298-1625	www.worklifecolorado.org or navigator@worklifecolorado.org

Updating Your Address/Phone Number

In order to ensure you receive your updated insurance cards and information, please make sure your contact information is up-to-date in Lawson. If your address and/or phone number has changed, you will need to complete the following steps:

- Go to the Pulse, and enter *LawsonGetItNow* in the address line.
- Log on with your normal user ID and password.
- Click on the *ESS-Benefits and HR* tab located on the left side of the screen.
- Click on the *Personal Information* tab, choose *Address Change* and update.
- To SAVE your changes, click on the *UPDATE* button.
- You will receive an email from **dhmessaging@velocityus.com** indicating you made a change.

Making an address change in ESS will automatically update the following areas: Payroll, Benefits, HR, Accounts Payable, and benefit vendors (Fidelity, DHMP, and Delta Dental).

DENVER HEALTH™
est. 1860
FOR LIFE'S JOURNEY

This brochure highlights the main features of the Denver Health Employee Benefits Program. It does not include all plan rules, details, limitations, and exclusions. The terms of your benefit plans are governed by legal documents, including insurance contracts. Should there be an inconsistency between this brochure and the legal plan documents, the plan documents are the final authority. Denver Health reserves the right to change or discontinue its employee benefits plans at any time.