Employee Benefits Guide

2020

You & your benefits

A partnership for good health

DENVER HEALTH
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FOR LIFE'S JOURNEY

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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.

A Message From Our CEO

Dear Colleagues,

With summer coming to a close, it's time to think about open enrollment for 2020 employee benefits. Your benefits are a big part of your overall compensation package, and we hope that you'll take this opportunity to review the programs offered and make a thoughtful choice that will meet the needs of you and your family.

Earlier this year we asked you to tell us what was working well with our employee benefits program, and what we could improve. We received an incredible response and I wanted to thank you for providing us with your feedback. We went through all of your comments, and as a result are adding some additional benefits such as adoption assistance, and a leave sharing program based on your feedback. The average age of our employee workforce has been decreasing as we hire in new team members, and as a result, we have been asked several times about implementing a paid family leave policy that employees can use when they are welcoming a new child into their family.

As we began our due diligence process, the Colorado legislature began creating the CO FAMLI act, which, if passed into law, will require employers to provide paid family leave. The act is expected to come up for a vote in the 2020 session. With this development, we decided that our best course of action would be to wait until the act is passed as opposed to implementing our own leave policy at this time. In the meantime, we are evaluating at what we can do to help with family care services, and student loan debt. More to come in 2020.

Just like other employers, Denver Health walks a balance between have the best benefits possible and the cost to the organization. This year we're pleased to let you know that we are not changing the features of our benefit programs. In order to keep these programs intact, the cost of the premium we pay for these benefits is increasing. Specifically, the Highpoint HMO, and Highpoint POS medical plans received a large increase this year due to a number of members receiving services outside of the Denver Health network.

Denver Health continues to shoulder the majority of this cost - close to 90%, but if you are enrolled in one of these plans you will see a larger increase to your per pay check deduction than if you are enrolled in the Denver Health HMO plan. If you are not enrolled in the Denver Health HMO plan, consider making the switch. You'll pay less in premium, less out of pocket when you use services, and help Denver Health keep our benefit costs low.

Take a moment to review this the information before making your choices for 2020. If you have questions contact our Health Advocate call center any time at (866) 799-2728, or email us at benefits@dhha.org. Open Enrollment begins October 14, and ends October 31.

Thank you for all you do.

Robin D. Wittenstein, Ed.D., FACHE

Chief Executive Officer

Important Contacts

Denver Health and Hospital Authority
HR Employee Benefits Center
601 Broadway – 5th Floor
Mail Code 0115

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

Company	Phone Number	Website/Email
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 Health Appointment Line	720-956-2227	N/A
Denver Health Medical Plan	303-602-2100	www.denverhealthmedicalplan.org
Denver Health Resiliency in Stressful Events (RISE) *	303-436-RISE	DHRISE@dhha.org
DERP (Denver Employee Retirement Plan)	303-839-5419	www.derp.org
Discovery Benefits (FSAs)	866-451-3399	www.DiscoveryBenefits.com
Dispatch Health	720-588-9686	www.dispatchhealth.com
Fidelity Investments – 401(a) & 457(b)	800-343-0860	www.fidelity.com/atwork
Health Advocate (Advocacy and EAP)	866-799-2728	HealthAdvocate.com/members answers@HealthAdvocate.com
MetLaw 3	800-821-6400	www.legalplans.com
MetLife (Auto, Boat, Home, Renter Ins., etc.)	800-438-6381	www.metlife.com/mybenefits
Nurseline	303-739-1211	N/A
Short-Term Disability (HR LOA Center)	303-602-7007	LOAFMLProcess@dhha.org
Unum Life Insurance (Life & AD&D)	800-421-0344	www.unum.com
Vision Service Plan (VSP)	800-877-7195	www.vsp.com
WorkLife Partnership of Colorado	303-298-1625	www.worklifecolorado.org or navigator@worklifecolorado.org

*Available 1/1/20

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 our HRIS system.

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

What’s New in 2020?

Enhancements and Changes

Based on your feedback we’re excited to provide you with these exciting enhancements to your employee benefits plan beginning on January 1, 2020.

NEW Adoption Assistance program. All benefit eligible employees can receive a lump sum payment of $8,700 when they adopt a child. The benefit is available to employees who have been in a benefit eligible position for at least 12 months prior to the finalization of the adoption. One payment is available per family per year regardless of number of children adopted, and is payable for all types of adoptions with the exception of step children already in the custody of a biological parent. The full policy and the applications will be available on the Pulse, and in the MyHR office.

NEW Employee Leave Sharing program. Beginning on 1/1/2020, this benefit will allow you to donate PTO to a fellow employee in need. The donation is voluntary and tax free to the donating employee. Employees may receive leave donations if they experience a medical emergency for themselves or their immediate family, or the death of an immediate family member. Recipient employees must be on an approved leave of absence, do not qualify for disability benefits, have used all available PTO, and are expected to be out for at least 2 weeks. The Leave of Absence office will manage all applications and donations. The full policy will be viewable on PolicyStat.

NEW Income Tax-free Short and Long Term Disability benefits. Beginning on 1/1/2020, employees who qualify for disability benefits will receive those payments without having to pay income taxes on the amounts received. This means that more of our team members will receive a full paycheck when they are unexpectedly injured or ill and unable to work.

Legal Plan Upgrade – Based on your feedback we are upgrading our voluntary legal plan, Hyatt Legal, to MetLaw 3. The new plan includes more coverage to protect you from identity theft, and to provide more assistance for family law matters. Employees currently enrolled in the Hyatt Legal plan will be automatically enrolled in the new benefit, and the premium increase of $2.50 per month will begin in January. Employees wishing to enroll in the plan, or cancel their current coverage can do so in Lawson during open enrollment.

Other Benefit Information

We are not making any changes to the benefits under the Medical, Dental, Vision or Life insurance programs. The premiums for Medical and Dental coverage are changing, and more information can be found on pages 13 and 14 of this guide, available on the Pulse, and through the enrollment site on Lawson.

Any changes made to your benefit elections will take effect on January 1, 2020. Your new premium deductions will be taken out of your paycheck on January 14th, 2020.

Eligibility

IMPORTANT REMINDER!

As a new hire employee or when you have a qualifying life event, you must choose your benefit elections and complete your enrollment for coverage within 30 days of your hire date or life event to receive benefits for the remainder of the 2020 plan year. If you don't make your elections and complete enrollment during this enrollment period, you will have to wait until the next Open Enrollment period to choose benefits.

Who's Eligible for Benefits?

- Full-time employees who regularly work 30 - 40 hours a week. (.75 - 1.0 FTE)
- Part-time employees who work between 20 and 30 hours a week. (.5 - .749 FTE)

Who is an Eligible Dependent?

- A legal spouse, common-law spouse, domestic partner, or Colorado Civil Union.
- A married or unmarried child, age 26 and younger, or dependent children over age 26 if permanently disabled.
- 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.

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 30 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 18 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.

Who is NOT an Eligible Dependent?

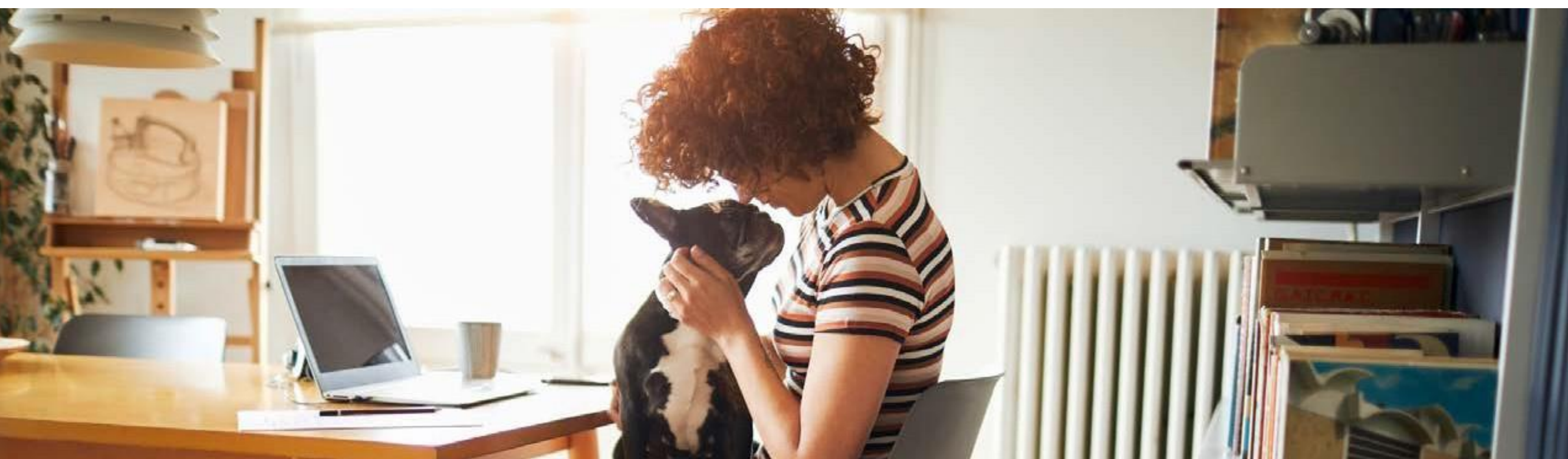
- An ex-spouse, ex-common-law spouse, an ex-domestic partner, an ex-Colorado Civil Union, a parent or parent-in-law.
- Grandchildren, siblings, nephews, nieces, cousins, aunts, uncles and grandparents.

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

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** or via email at **benefits@dhha.org**.



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 at 303-602-7000 or benefits@dhha.org.

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 provide appropriate documentation shown in the table below within 30 days from the Qualifying Life Event date. If you do not make your change within the 30-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 – photo copies accepted	Permitted Changes
Marriage	Marriage License or Certificate	Can add new dependents to existing plans; enroll in health, dental, and vision plans; change FSA election or amount. 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. Change FSA election or amount. 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, Hospital Certificate, or The Hospital Birth Worksheet	Can add spouse/domestic partner and newborn to existing plan. Change FSA election or amount. 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. Change FSA election or amount. Must provide proof coverage lost in last 30 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	No documentation required	Enroll in all benefit options.
Dependent Reaching Ineligible Age	No documentation required	Remove ineligible dependent; change FSA election or amount.
Medicare Eligibility for You or Your Spouse	Proof of Medicare Eligibility must be within 60 days	Opt out of health, dental, vision benefits, and change FSA election or amount.
Medicare/Medicaid Eligibility for Your Dependent(s)	Proof of Medicare Eligibility must be within 60 days	
Eligibility for subsidized coverage under government exchange	Proof of eligibility and enrollment must be within 30 days	

* Letters must be on the business letterhead and provided by a Human Resources representative. The letter must provide appropriate information to determine if 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.

Denver Health Medical Plans

Denver Health employees can obtain detailed plan materials for the health plans from the Employee Benefits sub-site on the Pulse, from the Denver Health Medical Plan by reaching out at **303-602-2100** or **DHMPmemberservices@dhha.org**, or from the HR Benefits Center. It is important for you to carefully review all the plan literature and other information.

About Our Networks

Denver Health provides you with three different medical plans with different networks under the Denver Health Medical Plans (DHMP). 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 in a timely manner. Typically, “timely” means within 60 days. However, if the Member has a more urgent need, those timeframes can change.

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

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) between 7 AM – 7 PM MT Monday – Friday.

Waiving Medical Coverage

Employees wishing to waive Denver health medical coverage must provide proof of other medical coverage before they can be allowed to drop or waive coverage at time of hire, open enrollment, qualifying life event. This applies if you are a Full-Time Employee 0.75 or higher. Proof of other coverage must be provided within 30 days and can include but is not limited to a copy of your enrollment card with your name or letter from Human Resource department indicating benefit enrollment. For any additional questions please contact the HR Employee Benefits Center at 303-602-7000 or via email at benefits@dhha.org.

Medical Plan Comparison

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
Lowest copays	Higher copays	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 of $500 per individual/$1,000 per family for certain services.
No coinsurance, except for Durable Medical Equipment	No coinsurance, except for Durable Medical Equipment	Within Cofinity Network, 20% coinsurance for diagnostic and hospital services

Medical Plan Comparison *continued*

DHHA Medical Care HMO	HighPoint HMO	HighPoint POS
• 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 60 day timeframe, you will be referred to an appropriate out of network provider without any additional charge to you. • Medical Care Outside of Service Area – If you are outside of the DHMP service area and need emergency care, you may go to the nearest urgent care, hospital or call 9-1-1. Following an emergency or urgent care visit out of network, one follow-up visit is covered if you cannot reasonably travel back to your service area. If you are outside the DHMP service area and need your prescription filled, Denver Health has many network pharmacies across the country that you may use. Please check with Health Plan Services at 303-602-2100. DHMP members are NOT covered anywhere outside of the U.S. • Eligible Dependents Living Outside of Service Area – If your dependent is living outside of the DHMP service are they may qualify to use First Health network providers. To qualify, Health Plan Services must be notified by calling 303-602-2100. There is no prior authorization required for primary care providers, OB GYN or outpatient behavioral health. All other specialty care visits require prior authorization (except ER and Urgent Care). 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**

Medical Plan Comparison *continued*

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			Denver Health Facilities	**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.	$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 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 per family members 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.

Medical Plan Comparison *continued*

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			Denver Health Facilities	Cofinity
Coinsurance / Copays				
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**			
Nurseline	The Denver Health Nurseline is FREE to anyone who calls—you do not need to be a patient or employee or recently discharged. You can call and speak to a nurse anytime 24/7, 365. The main number is 303-739-1211. • The Nurseline can schedule basic primary care appointments if the appointment center is closed. • There is a doctor on staff most days Monday – Friday 12:00pm to 10:00pm. The nurses can consult with a doctor if the symptoms are concerning or emergent. • The Nurseline has some protocols that if a patient meets the requirements, they MAY be able to help prescribe medication over the phone. Examples include: Pink eye, UTI, Tamiflu, Plan B/Emergency Contraception, Head Lice, Scabies, Nausea and vomiting in adults or pregnant women.			
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	$400 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
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
Dispatch Health*	$50 copay	$50 copay	$50 copay	N/A

***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 or c**all **720-588-9686**

Medical Plan Comparison *continued*

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			Denver Health Facilities	Cofinity
Diagnostic Laboratory & Radiology – If services are received at Denver Health facility, copay is waived for a DHHA enrolled employee.				
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 test
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.)			
Renal Dialysis	Covered at 100%	Covered at 100%	Covered at 100%	Deductible and 20% coinsurance apply
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. If services are received at Denver Health facility, copay is waived for a DHHA enrolled employee.			
Pulmonary Rehabilitation & Cardiac Rehabilitation Therapies	$10 copay	$20 copay	$10 copay	Deductible and 20% coinsurance apply
	Limit of 20 visits of each therapy per calendar year.			
Behavioral Health, Mental Health Care and Substance Use Disorder Treatment				
Inpatient, Residential Treatment	$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

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
			Denver Health Facilities	Cofinity
Other				
Durable Medical Equipment	20% coinsurance applies			
Routine Eye Exams	20% coinsurance applies			
Chiropractic Care	$20 copay per visit at Columbine Chiropractic only Maximum of 20 visits per calendar year			
Vision Care Under Medical Plan (Supplemental Vision Plan available under VSP)				
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 to each enrolled member for prescription eyewear which includes adult contacts and/or glasses or for children (under 18 years old) contacts or one pair of glasses are included. Only one claim can be submitted in a 24-month period, i.e. if you are using the benefit for multiple expenses, you may consider waiting until you accumulate $350 in charges before submitting a claim to use the full benefit. $200 can be paid 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.			
Prescription Drug Copays – apply to all medical plans				
	Denver Health Pharmacy 30-day supply	**Denver Health Pharmacy or Denver Health Deliver-by-Mail** 90-day supply	**Non-DHHA Pharmacy** 30-day supply	**Non-DHHA Pharmacy** 90-day supply
Discount	$4	$8	$8	$16
Preferred Generic	$15	$30	$30	$60
Non-Preferred Generic	$25	$50	$50	$100
Preferred Brand	$40	$80	$80	$160
Non-Preferred Brand	$50	$100	$100	$200
Specialty	$60	N/A	$120	N/A
***For drugs on our approved list, call Managed Care Member Services at 303-602-2100.**				
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 Care under the Medical Plans is not covered. See Delta Dental of Colorado plans on page 15.				

2020 Employee Medical Premiums — Per Pay Period

24 of 26 Bi-Weekly Paychecks

	DHHA Medical Care HMO		HighPoint HMO		HighPoint POS	
	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**
Employee Only	$34.39	$85.98	$83.37	$125.06	$113.89	$142.36
Employee + Spouse	$73.04	$182.60	$177.05	$265.58	$241.08	$301.35
Employee + Child(ren)	$61.30	$153.26	$137.66	$222.90	$203.42	$254.27
Employee + Family	$101.45	$253.62	$245.91	$368.87	$329.29	$411.61

* 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 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 are listed below.

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.

2020 Employee Dental Premiums — Per Pay Period

24 of 26 Bi-Weekly Paychecks

	Delta Dental EPO 3C Basic		Delta Dental EPO 1B/ Preferred		Delta Dental PPO/Premier	
	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**	FULL-TIME*	PART-TIME**
Employee Only	$0.98	$3.90	$4.70	$8.54	$15.33	$19.00
Employee + 1	$2.15	$7.96	$8.69	$15.05	$27.81	$34.39
Employee + 2+	$3.53	$12.34	$16.42	$25.59	$41.87	$51.57

* 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 lifetime maximum		50% covered, maximum lifetime benefit of $1,100
Adult (D8090)	50% of charges up to $2,000 lifetime 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

	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	One benefit per family member every calendar year	$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

2020 Vision Premiums

24 of 26 Bi-Weekly Paycheck

Vision Plan	
Coverage	**Bi-Weekly Payments**
Single	$3.24
Two Party	$6.48
Family	$10.44

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	Plan Pays Up to $65
Frame	Plan Pays Up to $77
Single Vision Lenses	Plan Pays Up to $31
Lined Bifocal Lenses	Plan Pays Up to $50
Lined Trifocal Lenses	Plan Pays Up to $65
Progressive Lenses	Plan Pays Up to $50
Contacts	Plan Pays Up to $35

Extra Savings Available Through Vision Plan

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.

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.

Flexible Spending Accounts

Discovery Benefits

Benefit-eligible employees may choose to participate in Flexible Spending Accounts (FSA) through Discovery Benefits for the 2020 plan year. Denver Health provides 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.

How to Log into Your Account

If you have an email address on file with Discovery Benefits, you can create your account online. Just go to www.DiscoveryBenefits.com, click the Login button and select “HSA, FSA, HRA & Commuter Login.” Select Create your new username and password and complete the steps to activate your account.

If you don’t have an email address on file, Discovery Benefits will need to help you set up your online account. Please call them at 866-451-3399 within 30 days of joining Discovery Benefits to ensure you can access your account online when you need to.

Additionally, Discovery Benefits has a mobile app where you can access your benefits to get real-time access to your accounts in one spot 24/7. From the app, you can:

- Check your balance and view account activity
- Get instant notifications on the status of your claims
- File a claim and upload documentation in seconds using your phone’s camera
- Scan an item’s bar code with your phone’s camera to determine if it’s an IRS code Section 213(D) eligible expense.
- Report a card as lost or stolen
- Reset login credentials

Health Care Flexible Spending Account

The Health Care Flexible Spending Account allows employees to set aside between $240 and $2,700 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

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

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. Check www.discoverybenefits.com/employees/eligible-expenses for a list of all eligible expenses.

If you have funds left over at the end of the plan year and do not want to lose the money, you can access the FSA Store by visiting fsastore.com/discbene. The FSA store is exclusively stocked with FSA eligible products so there is no guessing about what is and what is not a reimbursable expense.

Dependent Care Flexible Spending Account (Day Care Expenses)

The Dependent Care Flexible Spending Account (Dependent Care FSA) allows employees to set aside between $240 and $5,000 per household per calendar year on a pretax basis for reimbursement for dependent care (day care) costs. Dependent Care FSA eligible expenses include:

- Care for children ages 12 and younger who are claimed as qualified dependents
  - Examples: Babysitter, nanny, or summer day camp
- Care for a disabled spouse or dependent of any age, including custodial care of an adult dependent
  - Per IRS regulations, the following must be true to use dependent care funds:
    - Such expenses are not for medical services
    - The elderly person is a qualifying individual
    - In case of services provided outside your household, the person still regularly spends at least eight hours each day in your household
- Examples of ineligible expenses include:
  - Costs already claimed as a dependent care tax credit on your tax return
  - Care at a nursing home, long-term care insurance premiums, respite care or other residential care center and services such as housework
  - Services provided by one of your dependents
  - Expenses while on vacation

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.

You have through April 15 of the following year to submit eligible expenses for reimbursement. You can incur expenses through March 15.

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

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.

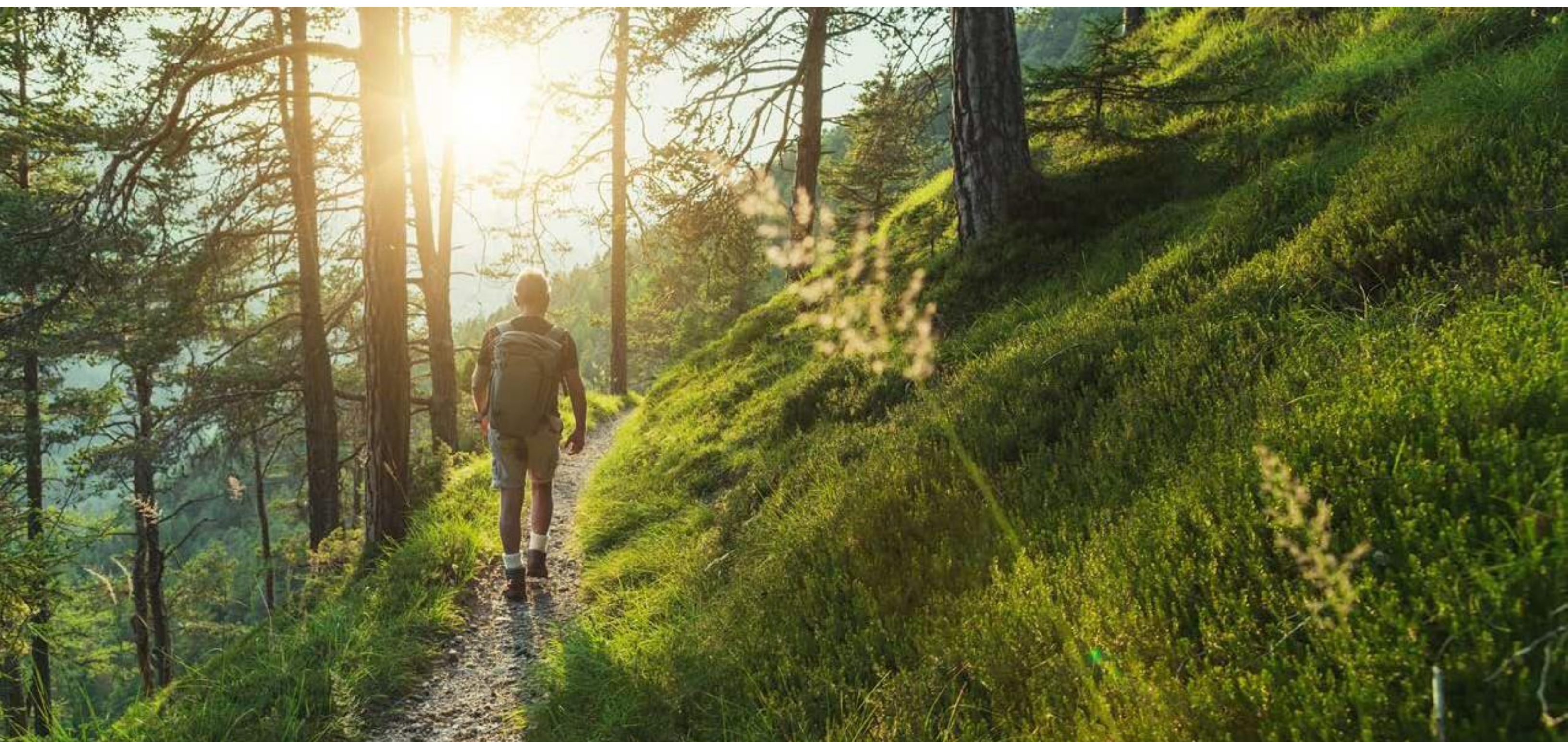
The maximum policy value for this plan is $500,000 for all employees, except physicians' and executives' maximum value is $1,000,000. This is a double indemnity policy that will pay double the policy's value in the event that the insured dies as a result of an accident.

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.

Voluntary Life Insurance and AD&D

As a new hire employee within 30 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 their spouse without having to answer medical questions. Employees can apply during open enrollment or at date of hire 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 if applied for outside of initial eligibility.



Disability Plans

Both Short-Term Disability (STD) and Long-Term Disability (LTD) coverage are designed to provide income replacement 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 the first of the months following six months of benefits eligible 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. After 26 weeks, Denver Health provides a LTD plan for eligible employees.

- STD is used concurrently with Family Medical Leave if eligible.
- STD is a 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 an 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. This coverage is provided by Denver Health and the cost is included in your annual taxable income. 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 per month.

Individual Disability Insurance — Unum

Denver Health Physicians and Executives are eligible to enroll in additional Individual Disability Insurance from Unum. Denver Health contributes to a portion of this benefit, but you are still required to complete an enrollment form which will be mailed to your home. The amount of income replacement, and premiums for any excess coverage will be listed in your individualized packet. This policy provides income replacement in addition to the STD and LTD policies provided by Denver Health. If you are eligible you will receive information from Unum directly.

Tuition Reimbursement

Denver Health recognizes the value and importance of an educated workforce. Employees who have been employed in a benefit eligible position 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. Keep in mind that HR Benefits pre-approval is required prior to class starting. For additional information, visit the Benefits Homepage of the Pulse and click on the Tuition Reimbursement link.

Full-Time Equivalent	Reimbursement Level Based on Full-Time Equivalent Status	2020 Annual Dollar Amount up to Bachelor Degree	2020 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
0.75	75%	$1,875	$2,625
0.7	70%	$1,750	$2,450
0.6	60%	$1,500	$2,100
0.5	50%	$1,250	$1,750

Voluntary Benefits

Critical Illness Insurance

Employees are able to purchase Critical Illness Insurance from Unum at discounted rates through payroll deductions. The Critical Illness policy pays a lump sum benefit in the event that an employee or family member is diagnosed with a named Critical Illness, such as a heart attack, cancer, or stroke. More details of all covered conditions can be found within the policy plan documents. Eligible employees can only enroll at open enrollment and other special events throughout the year which will be communicated by your HR team.

Whole Life Insurance

Employees are able to purchase Whole Life Insurance from Unum at discounted rates through payroll deductions. Whole Life policies provide permanent life insurance that you keep regardless of your employment status with Denver Health, and pay benefits in addition to our term life insurance benefit. Additionally, this policy provides Long Term Care benefits to assist employees in paying for the cost of skilled nursing home care with fixed premium rates over the life of the policy. Eligible employees can only enroll at open enrollment and other special events throughout the year which will be communicated by your HR team.

Group Legal Plan

The current Hyatt Legal program is being enhanced this year to MetLaw 3. The new plan includes more coverage for family law matters, consumer protections, and to provide more assistance for debt matters. The plan now also will include 4 hours of non-covered plan services in order to ensure more comprehensive legal plan coverage. The premium cost is slightly increasing by $2.50 per month for these additions. Benefit eligible employees wishing to enroll in the plan, or cancel their current coverage can do so during open enrollment.

MetLife Home and Auto

MetLife provides benefit eligible Denver Health employees with discounted Auto, Homeowners and Renters insurance through convenient payroll deductions. Contact MetLife at **800-438-6381** for a premium quote or to enroll. Free auto quotes are available at **autohome.metlife.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			
Completed Years of Service	Annual Accrual	Maximum Carry Over Hours	Maximum Hours
0 to 4 years	160 hours or 20 days	152 hours	312 hours
5 to 9 years	184 hours or 23 days	160 hours	344 hours
10 to 14 years	208 hours or 26 days	176 hours	384 hours
15 plus years	232 hours or 29 days	184 hours	416 hours

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

Bereavement Leave

In the event of the death of an immediate family member, employees will be given up to 24 paid leave hours annually. 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.

Leave Sharing

This benefit allows you to donate PTO to a fellow employee in need. The donation is voluntary and tax free to the donating employee. Employees may receive leave donations if they experience a medical emergency for themselves or their immediate family, or the death of an immediate family member. Recipient employees must be on an approved leave of absence, do not qualify for disability benefits, have used all available PTO, and are expected to be out for at least 2 weeks. The Leave of Absence office will manage all applications and donations. The full policy will be viewable on PolicyStat.

2020 DHHA Observed Holidays	
New Year's Day (observed)	Wednesday, January 1
Martin Luther King Day	Monday, January 20
Memorial Day	Monday, May 25
Independence Day	Saturday, July 4
Labor Day	Monday, September 7
Thanksgiving Day	Thursday, November 26
Christmas Day	Friday, December 25

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.

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 $19,500. Employees age 50 or older can invest up to $26,000. 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 **www.netbenefits.com/denverhealth** or through Fidelity's call center at **800-343-0860**.

Employees can meet with a Denver Health Fidelity Representative for a one-on-one meeting to discuss your Fidelity retirement plan. Meetings require an appointment. Please call 800-642-7131 to schedule an appointment or visit fidelity.com/atwork/reservations.

Retirement Planning

Making the most of your retirement benefits is important to ensure you're ready for the next phase of your life. Whether your retirement is right around the corner or decades away, planning ahead is key – Denver Health can help.

Keep reading to learn how the Denver Health Retirement Plan works and how you can make the most of this valuable benefit.

How the Plan Works

You and Denver Health both contribute to the Denver Health Retirement Plan, and there are two main types of contributions available:

1. Mandatory Contributions

You *cannot* opt-out of these contributions, and they are made to your **401(a) Plan account**.

- **Employee and Denver Health Social Security Replacement Contributions**—You and Denver Health both make mandatory contributions to a personal retirement account each pay period. Unlike traditional Social

  Security payments, you have the opportunity to invest the contributions according to your personal risk tolerance and time horizon. **You contribute 6.2%** of your eligible pay (up to $280,000 in 2020) and **Denver Health contributes 3%** of your eligible pay (up to $132,900 in 2020).
- **Denver Health Contribution—Denver Health contributes 3%** of your eligible pay (up to $280,000 in 2020). Intermittent employees and DERP participants are not eligible for these contributions.

2. Voluntary Contributions

The amount of these contributions varies, depending on what you contribute to the Plan.

- **Employee Voluntary Contribution—You can make additional contributions in your 457(b) Plan account** to help you reach your personal savings goals, up to the IRS limit of $19,500 in 2020. You can choose to make these contributions on a traditional pre-tax or Roth after-tax basis.
- **Denver Health Matching Contribution**—When you make voluntary contributions to the 457(b) Plan account, **Denver Health provides a dollar-for-dollar match, up to 3.5%** of your eligible pay (up to $280,000 in 2020). These matching contributions are made to your **401(a) Plan account and not your 457(b) Plan account**. Intermittent employees and DERP participants are not eligible for these contributions.

Did You Know?

The Denver Health Retirement Plan consists of two parts:

- 401(a) Plan for all Social Security replacement contributions and contributions made by Denver Health
- 457(b) Plan for your Employee Voluntary Contributions

Contribution Type	Who Makes the Contribution?	How Much is the Contribution?
Mandatory Contributions (12.2%) made by you and Denver Health into your 401(k) Plan regardless of whether you make any voluntary		
Employee Social Security Replacement Contribution	You	6.2%
Denver Health Social Security Replacement Contribution	Denver Health	3%
Denver Health Contribution*	Denver Health	3%
Voluntary Contributions made by you and Denver Health		
Employee Voluntary Contribution (made into your 457(b) Plan account)	You	You can contribute up to the 2020 IRS limit of $19,500. If you will be age 50 or older in 2020, you can contribute an additional $6,500.
Denver health Matching Contribution* (made into your 401(a) Plan account)	Denver Health	Dollar-for-dollar match up to 3.5% of your eligible pay.

* Intermittent employee and DERP participants are not eligible for these contributions.

How Does the Social Security Replacement Benefit Work?

Denver Health provides a Social Security Replacement Benefit that offers you additional flexibility and control over your contributions, as compared to the Federal Social Security program. You contribute 6.2% of your eligible pay each paycheck (up to the Social Security Wage Base)—the same amount you would contribute if you were paying directly to Social Security—and Denver Health contributes 3% (up to the Social Security Wage Base). But rather than making payments to the governmental program, your contributions are made to a personal retirement account that you can manage according to your own investment strategy, risk tolerance, and time horizon. These contributions are yours to keep and to manage as you see fit.

Denver Health and its employees do not participate in the Federal Social Security program. This means you do not pay Social Security taxes on your Denver Health pay and you do not earn additional Social Security credits while you work here.

Making Voluntary Contributions

Social Security alone isn't enough to fully support most people during retirement, and neither is the Social Security Replacement Benefit under the Denver Health Retirement Plan.

In fact, saving 15% of eligible pay including both employee and employer contributions—on top of Social Security— can help ensure you'll have enough to last through retirement. Denver Health's Plan is designed to help you reach this savings goal.

Save Even More with the Denver Health Company Match

Denver Health offers a dollar-for-dollar match to help encourage you to actively save for retirement. For every dollar you contribute through your employee voluntary contributions, Denver Health will also contribute a dollar to your account, up to 3.5% of eligible pay (up to $280,000 in 2020). If you don't make employee voluntary contributions of at least 3.5% to the Plan, it's like you're missing out on "free" money.

Employee Well-being Benefits and Perks

Physical, Financial, Mental, Social

Denver Health cares about YOU! As an employee at Denver Health you have access to many benefits and resources that support Total Worker Health - a holistic approach that supports worker safety, health, and well-being.

Health Advocate Call Center

The Health Advocate Call Center advocates are available from 8 AM to 10 PM for benefit questions. For EAP related questions, you can call 24/7. You can reach an advocate 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

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.

- 5 face-to-face sessions per incident per family member per year
- Confidential
- EAP is 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.
- Email at answers@HealthAdvocate.com

WorkLife Partnership: Better Work. Better Life.

Denver Health partners with WorkLIfe to provide resources and assistance to help you overcome work-life challenges. WorkLife services are always free and confidential.

Examples of how WorkLife Navigators may help:

- Help determine the best housing for your situation and guide you to search options and financial assistance for things like a deposit.
- Help find reliable and affordable transportation options.
- Find budgeting solutions for debt issues, help apply for hospital assistance programs, or help to understand medical bills.
- Help navigate employee assistance programs or other community resources to find free or low cost options for counseling and/or legal services.
- Accessing Resources for Affordable childcare.

Contact a WorkLife Navigator at 303-289-1625, text NAVIGATOR to 555888, or email denverhealth@worklifecolorado.org

Resilience in Stressful Events (RISE): Peer Support for Caregivers in Distress

Denver Health RISE is a hospital-based program created by Johns Hopkins Medicine and Maryland Patient Safety Center. DH RISE Peer Responders are available 24/7 to provide immediate, confidential peer to peer support to all caregivers who experience distressing events at work- the unexpected loss of a patient; a troubling encounter with a family member; an adverse clinical care situation; work place violence; or a medication error. Email DHRISE@dhha.org or call 303-436-RISE for more information.

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.
- The fitness center is approximately 1900 square feet and includes cardio equipment, strength training machines, free weights, a small group fitness studio and full service lockers rooms with day-use lockers and showers.
- Membership is available to all Denver Health and Hospital Authority and CSA employees, contract personnel, physician residents and Denver Health volunteers.
- Membership dues are $7.50 per pay period.
- Fitness classes are included in membership!
- Email at fitness.center@dhha.org

Healthy Hospital Initiative

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. Denver Health is continuously improving the nutritional offerings by way of healthier food, beverages, marketing, and breastfeeding support to create a culture and organization that promotes health and well-being. Denver Health is proud to be involved with the Colorado Healthy Hospital Compact which supports our vision to make Denver the healthiest community in the United States.

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.

Denver Parks and Recreation Discount

All DHHA employees may purchase annual Regional, Local, or Neighborhood tier memberships at a discount (25% off Denver resident rates). Benefit eligible employees (FTE .5 or higher) may enroll in Denver Parks and Recreation's (DPR) payroll deduction program to arrange for payment in monthly installments from their paychecks. Family memberships also available to all individuals in an employee's household at 50% with the purchase of an employee membership. Access the payroll deduction form from the pulse or email benefits_department@dhha.org.

RTD Eco Pass

All Denver Health and CSA employees in a 0.5 FTE or higher are eligible to receive an RTD EcoPass. Intermittent employees are not eligible to participate per our contract with RTD. Employees may enroll for the EcoPass at any time during the calendar year. Applications for the EcoPass and to pick up your printed pass, visit MyHR between 7:30 AM – 5 PM M-F, located at 601 Broadway, 5th floor. Employees who terminate employment with Denver Health will have their EcoPass badge deactivated. There is no cost to eligible employees to apply for the EcoPass. Denver Health will assess a $10 fee for lost, misplaced or unaccounted for EcoPass badges. Pursuant to the EcoPass contract, RTD or Denver Health may confiscate and prosecute unauthorized use of the EcoPass.

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: 1-800-221-3943

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 2020. 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 2020 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 avariety 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
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 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 eligible dependents, provided that you request enrollment within 30 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 30 – 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 of 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, the HR Employee Relations Department is available to help you.

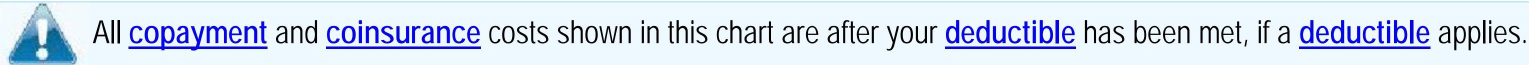
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

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

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-700-8140. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at www.denverhealthmedicalplan.org or call 1-800-700-8140 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0 individual/$0 family.	Generally, you must pay all of the costs from providers, up to the deductible amount before this plan begins to pay. An embedded plan has individual deductibles and a max out-of-pocket. Cost-sharing begins when the member reaches their individual deductible (including copayment).
Are there services covered before you meet your deductible?	Yes. Preventive care services and preventive pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,350 individual/$8,700 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, all family member's expenses will count towards the overall family out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit
Will you pay less if you use a network provider?	Yes. See https://www.denverhealthmedicalplan.org/ or call 1-800-700-8140 for a list of network providers.	This plan uses Denver Health and Hospital Authority and the Denver Health provider network. The Columbine network is used for chiropractic services. Cofinity providers are in-network for outpatient mental health services only. Please be aware, your network provider may use an out-of-network provider for some services such as lab work. Check with your provider before you receive services. Out-of-network providers are not covered on this plan except for urgent care or emergency.
Do you need a referral to see a specialist?	Yes, for some providers.	For Denver Health and Hospital Authority, you will need a referral to see most specialists.



All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Denver Health Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	Not covered	Three PCP visits at $0 cost-sharing per year at Denver Health facilities only.
	Specialist visit	$30 copay/visit	Not covered	A referral may be required.
	Preventive care/ screening/ immunization	$0 copay	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/test	Not covered	---------none----------
	Imaging (CT, PET scans, MRIs)	$0 copay/CT* $150 copay/MRI and PET*	Not covered	*Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.denverhealthmedicalplan.org	Discount drugs/ Generic drugs (Tier 1)/ Non-preferred generic (Tier 2)	**30-day supply:** DH Pharmacy: $4 copay (discount)/ $15 copay (preferred generics)/ $25 copay (non-preferred generics); National Network Pharmacy: $8 copay (discount)/ $30 (preferred generics)/ $50 copay (non-preferred generics) **90-day supply:** DH Pharmacy $8 copay (discount)/ $30 copay (preferred generics)/ $50 copay (non-preferred generics); National Network Pharmacy: $16 copay (discount)/ $60 (preferred generics)/ $100 copay (non-preferred generics)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 3)	**30-day supply:** DH Pharmacy $40 copay; National Network Pharmacy $80 copay **90-day supply:** DH Pharmacy $80 copay; National Network Pharmacy $160 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Denver Health Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.denverhealthmedicalplan.org	Non-preferred brand drugs (Tier 4)	**30-day supply:** DH Pharmacy $50 copay; National Network Pharmacy $100 copay **90-day supply:** DH Pharmacy $100 copay; National Network Pharmacy $200 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Specialty drugs (Tier 5)	**30-day supply**: DH Pharmacy $60 copay; National Network Pharmacy $120 copay **90-day supply:** DH Pharmacy N/A; National Network Pharmacy N/A	Not covered	Covers up to a 30-day supply (retail Prescription-DH Pharmacy only); 31-90 day supply (mail order prescription) is not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/surgery*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Waived if admitted (inpatient copay then applies).
	Emergency medical transportation	$150 copay/transport	$150 copay/transport	---------none----------
	Urgent care	$50 copay/visit	$50 copay/visit	Dispatch Health included.
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/hospital stay*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Not covered	*Pre-authorization required.
If you need mental health, behavioral health or substance use services	Outpatient services	$10 copay/visit for Denver Health providers $25 copay/visit for Cofinity providers	Not covered	---------none----------
	Inpatient services	$400 copay/admission*	Not covered	*Pre-authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Denver Health Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$0 copay/visit	Not covered	Preventive/prenatal visits and one postnatal visit have a $0 copay. Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	$200 copay/admission	Not covered	---------none----------
If you need help recovering or have other special health needs	Home health care	$0 copay*	Not covered	*Pre-authorization required.
	Rehabilitation services	$10 copay/visit	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy (occupational, physical, speech).
	Habilitation services	$10 copay/visit	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy (occupational, physical, speech).
	Skilled nursing care	$0 copay*	Not covered	*Pre-authorization required. Coverage limited to 100 days per calendar year
	Durable medical equipment	$20% coinsurance *	Not covered	*Pre-authorization may be required. Limited to $2,000 per calendar year.
	Hospice services	$0 copay*	Not covered	*Pre-authorization required. Each benefit period has a duration of three months.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit at Denver Health Eye Clinic or One-Hour Optical	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	$350 reimbursement*	Not covered	*Only one claim may be submitted every 24 months.
	Children's dental check-up	Not covered	Not covered	Fluoride varnish at PCP visit covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Elective abortions • Cosmetic surgery • Dental care (adult/child)	• Long-term care • Infertility treatment • Routine foot care	• Weight loss programs • Acupuncture • No coverage provided outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Oxygen • Chiropractic care	• Hearing aids • Routine eye care (adult, child)	• Private-duty nursing (when medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa, or U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Denver Health Medical Plan, Inc. at 1-800-700-8140 or www.denverhealthmedicalplan.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 303-602-2100 / 1-800-700-8140.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-602-2100 / 1-800-700-8140.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 303-602-2100 / 1-800-700-8140.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-602-2100 / 1-800-700-8140.

———————————To see examples of how this plan might cover costs for a sample medical situation, see the next section.———————————

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $0
- Specialist copayment $30 per visit
- Hospital (facility): $200 copay
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(laboratory)*

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

Managing Joe's Type 2 Diabetes
(A year of routine in-network care of a well- controlled condition)

- The plan's overall deductible: $0
- Specialist copayment $30 per visit
- Hospital (facility): N/A
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including diabetes education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred generic by mail)*
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$340
Coinsurance	$346
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$741**

Mia's Simple Fracture
(In-network emergency room visit and follow up care)

- The plan's overall deductible: $0
- Specialist copayment $30 per visit
- Hospital (facility): $150 copay
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

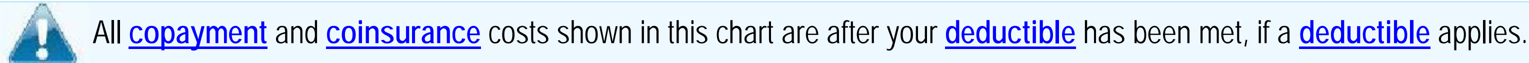
In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$187**

The plan would be responsible for the other costs of these EXAMPLE covered services. * *Values shown are estimates for services received at Denver Health facilities*

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-700-8140. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at www.denverhealthmedicalplan.org or call 1-800-700-8140 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$100 individual/$200 family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. An embedded plan has individual deductibles and a max out-of-pocket. Cost-sharing begins when the member reaches their individual deductible (including copayment).
Are there services covered before you meet your deductible?	Yes. Preventive care services and preventive pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	$5,000 individual/$10,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, all family members' expenses will count towards the overall family out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.denverhealthmedicalplan.org or call 1-800-700-8140 for a list of network providers.	This plan uses Denver Health and Hospital Authority, UC Health, CU Health Partners, Colorado Pediatric Partners and the Children's Hospital Colorado provider network. The Columbine network is used for chiropractic services. Cofinity providers are in-network for outpatient mental health services only. Please be aware, your network provider may use an out-of-network provider for some services (such as lab work). Check with your provider before you receive services. Out-of-network providers are not covered on this plan except for urgent care or emergency.
Do you need a referral to see a specialist?	Yes, for some providers.	For Denver Health and Hospital Authority, you will need a referral to see most specialists. Within the HighPoint network, you do not need a referral for claim payment, but the specialist may request a referral from your PCP prior to care.


All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Highpoint Denver Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	Not covered	Three PCP visits at $0 cost-sharing per year at Denver Health facilities only.
	Specialist visit	$40 copay/visit	Not covered	A referral may be required.
	Preventive care/ screening/ immunization	$0 copay	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/test	Not covered	---------none----------
	Imaging (CT, PET scans, MRIs)	$0 copay/CT* $150 copay/PET* $250 copay/MRI*	Not covered	*Pre-authorization required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.denverhealthmedicalplan.org	Discount drugs/ Generic drugs (Tier 1)/ Non-preferred generic (Tier 2)	**30-day supply:** DH Pharmacy $4 copay (discount)/ $15 copay (preferred generics)/ $25 copay (non-preferred generics); National Network Pharmacy $8 copay (discount)/ $30 (preferred generics)/ $50 copay (non-preferred generics) **90-day supply:** DH Pharmacy $8 copay (discount)/ $30 copay (preferred generics)/ $50 copay (non-preferred generics); National Network Pharmacy $16 copay (discount)/ $60 (preferred generics)/ $100 copay (non-preferred generics)	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 3)	**30-day supply:** DH Pharmacy $40 copay; National Network Pharmacy $80 copay **90-day supply:** DH Pharmacy $80 copay; National Network Pharmacy $160 copay	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Highpoint Denver Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.denverhealthmedicalplan.org	Non-preferred brand drugs (Tier 4)	**30-day supply:** DH Pharmacy $50 copay; National Network Pharmacy $100 copay **90-day supply:** DH Pharmacy $100 copay; National Network Pharmacy $200 copay.	Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Specialty drugs (Tier 5)	**30-day supply**: DH Pharmacy $60 copay; National Network Pharmacy $120 copay **90-day supply:** DH Pharmacy N/A; National Network Pharmacy N/A	Not covered	Covers up to a 30-day supply (retail Prescription-DH Pharmacy only); 31-90 day supply (mail order prescription) is not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$400 copay/surgery*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Waived if admitted (inpatient copay then applies).
	Emergency medical transportation	$150 copay/transport	$150 copay/transport	---------none----------
	Urgent care	$50 copay/visit	$50 copay/visit	DispatchHealth included.
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 copay/hospital stay*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Not covered	*Pre-authorization required.
If you need mental health, behavioral health or substance use services	Outpatient services	$10 copay/visit for Denver Health providers $35 copay/visit for HighPoint or Cofinity providers	Not covered	---------none----------
	Inpatient services	$600 copay/admission*	Not covered	*Pre-authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Highpoint Denver Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$0 copay/visit	Not covered	Preventive/prenatal visits and one postnatal visit are a $0 copay. Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	$400 copay/admission	Not covered	Cost sharing may apply for additional services.
If you need help recovering or have other special health needs	Home health care	$0 copay*	Not covered	*Pre-authorization required.
	Rehabilitation services	$20 copay/visit	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy (occupational, physical, speech).
	Habilitation services	$20 copay/visit	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy (occupational, physical, speech).
	Skilled nursing care	$0 copay*	Not covered	*Pre-authorization required. Coverage limited to 100 days per calendar year.
	Durable medical equipment	$20% coinsurance*	Not covered	*Pre-authorization may be required. Limited to $2,000 per calendar year.
	Hospice services	$0 copay*	Not covered	*Pre-authorization required. Each benefit period has a duration of three months.
If your child needs dental or eye care	Children's eye exam	$40 copay/visit at Denver Health Eye Clinic or One-Hour Optical	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	$350 reimbursement*	Not covered	*Only one claim may be submitted every 24 months.
	Children's dental check-up	Not covered	Not covered	Fluoride varnish at PCP visit covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Elective abortions • Cosmetic surgery • Dental care (adult/child)	• Long-term care • Infertility treatment • Routine foot care	• Weight loss programs • Acupuncture • No coverage provided outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Oxygen • Chiropractic care	• Hearing aids • Routine eye care (adult, child)	• Private-duty nursing (when medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa, or U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Denver Health Medical Plan, Inc. at 1-800-700-8140 or www.denverhealthmedicalplan.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
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Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-602-2100 / 1-800-700-8140.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 303-602-2100 / 1-800-700-8140.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-602-2100 / 1-800-700-8140.

–––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.–––––––––––––––––––––

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $100
- Specialist copayment $40 per visit
- Hospital (facility): $400 copay
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(laboratory)*

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$460
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$620**

Managing Joe's Type 2 Diabetes
(A year of routine in-network care of a well- controlled condition)

- The plan's overall deductible: $100
- Specialist copayment $40 per visit
- Hospital (facility): N/A
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including diabetes education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred generic by mail)*
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,390

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$240
Coinsurance	$446
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$841**

Mia's Simple Fracture
(In-network emergency room visit and follow up care)

- The plan's overall deductible: $100
- Specialist copayment $40 per visit
- Hospital (facility): $150 copay
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$2,128

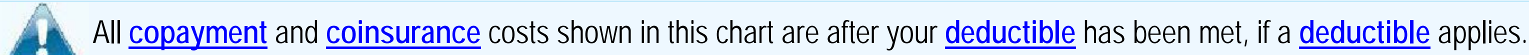
In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$190
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$297**

The plan would be responsible for the other costs of these EXAMPLE covered services. **Values shown are estimates for services received at Denver Health facilities*

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-700-8140. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider or other underlined terms see the Glossary. You can view the Glossary at www.denverhealthmedicalplan.org or call 1-800-700-8140 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible?	$0 individual/$0 family for HighPoint network or $500 individual/$1,000 family for Cofinity network.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. An embedded plan has individual deductibles and a max out-of-pocket. Cost-sharing begins when the member reaches their individual deductible (including copayment).
Are there services covered before you meet your deductible?	Yes. Preventive care services and preventive pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet other deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,350 individual/$8,700 family for HighPoint network or $5,000 individual/$10,000 family for Cofinity network.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on this plan, all family member's expenses will count towards the overall family out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.denverhealthmedicalplan.org/ or call 1-800-700-8140 for a list of network providers.	This plan uses Denver Health and Hospital Authority, UC Health, CU Health Partners, Colorado Pediatric Partners, Children's Hospital Colorado and the Cofinity provider network. The Columbine network is used for chiropractic services. Please be aware, your network provider may use an out-of-network provider for some services such as lab work. Check with your provider before you receive services. Out-of-network providers are not covered on this plan except for urgent care or emergency.
Do you need a referral to see a specialist?	Yes, for some providers.	For Denver Health and Hospital Authority, you will need a referral to most specialists. Within the HighPoint and Cofinity networks, you do not need a referral for claim payment, but the specialist may request a referral from your PCP prior to care.



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HighPoint Denver Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	$30 copay/visit	Not covered	Three PCP visits at $0 cost-sharing per year at Denver Health facilities only.
	Specialist visit	$30 copay/visit	$40 copay/visit	Not covered	A referral may be required.
	Preventive care/ screening/immunization	$0 copay	$0 copay	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	$0 copay/test	Deductible and 20% coinsurance apply	Not covered	---------none----------
	Imaging (CT, PET scans, MRIs)	$0 copay/CT* $150 copay/MRI and PET*	Deductible and 20% coinsurance/CT* $150 copay/PET* $250 copay/MRI*	Not covered	*Pre-authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.denverhealthmedicalplan.org	Discount drugs/ Generic drugs (Tier 1)/ Non-preferred generic (Tier 2)	**30-day supply:** DH Pharmacy: $4 copay (discount)/ $15 copay (preferred generics)/ $25 copay (non-preferred generics); National Network Pharmacy: $8 copay (discount)/ $30 (preferred generics)/ $50 copay (non-preferred generics) **90-day supply:** DH Pharmacy $8 copay (discount)/ $30 copay (preferred generics)/ $50 copay (non-preferred generics); National Network Pharmacy: $16 copay (discount)/ $60 (preferred generics)/ $100 copay (non-preferred generics)		Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs (Tier 3)	**30-day supply:** DH Pharmacy $40 copay; National Network Pharmacy $80 copay **90-day supply:** DH Pharmacy $80 copay; National Network Pharmacy $160 copay		Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Non-preferred brand drugs (Tier 4)	**30-day supply:** DH Pharmacy $50 copay; National Network Pharmacy $100 copay **90-day supply:** DH Pharmacy $100 copay; National Network Pharmacy $200 copay		Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HighPoint Denver Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
	Specialty drugs (Tier 5)	**30-day supply**: DH Pharmacy $60 copay; National Network Pharmacy $120 copay **90-day supply:** DH Pharmacy N/A; National Network Pharmacy N/A		Not covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription) is not available.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$200 copay/surgery*	Deductible and 20% coinsurance apply*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	$150 copay/visit	Waived if admitted (inpatient cost share then applies).
	Emergency medical transportation	$150 copay/transport	$150 copay/transport	$150 copay/transport	---------none----------
	Urgent care	$50 copay/visit	$50 copay/visit	$50 copay/visit	*Includes DispatchHealth
If you have a hospital stay	Facility fee (e.g., hospital room)	$400 copay/hospital stay*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	*(Included in copayment above)**	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If you need mental health, behavioral health or substance use services	Outpatient services	$10 copay/visit for Denver Health providers $25 copay/visit for Highpoint providers	$30 copay/visit	Not covered	---------none----------
	Inpatient services	$400 copay/admission*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions & Other Important Information
		HighPoint Denver Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$0 copay/visit	$0 copay/visit	Not covered	Preventive/prenatal visits and one postnatal visit have a $0 copay. Cost sharing may apply for additional services.
	Childbirth/delivery professional/facility services	$200 copay/admission	Deductible and 20% coinsurance	Not covered	Cost sharing may apply for additional services.
If you need help recovering or have other special health needs	Home health care	$0 copay*	$0 copay after deductible*	Not covered	*Pre-authorization required.
	Rehabilitation services	$10 copay/visit	Deductible and 20% coinsurance*	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy (speech, occupational, physical).
	Habilitation services	$10 copay/visit	Deductible and 20% coinsurance*	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy (speech, occupational, physical).
	Skilled nursing care	$0 copay*	$0 copay after deductible*	Not covered	*Pre-authorization required. Coverage is limited to 100 days per calendar year
	Durable medical equipment	20% coinsurance*	20% coinsurance*	Not covered	*Pre-authorization may be required. Limited to $2,000 per calendar year.
	Hospice services	$0 copay*	Deductible, then 100% covered*	Not covered	*Pre-authorization required. Each benefit period has a duration of three months.
If your child needs dental or eye care	Children's eye exam	$30 copay/visit at Denver Health Eye Clinic or One-Hour Optical	$40 copay/visit	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	$350 reimbursement*	$350 reimbursement*	Not covered	*Only one claim may be submitted every 24 months.
	Children's dental check-up	Not covered	Not covered	Not covered	Fluoride varnish at PCP visit covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Elective abortions • Cosmetic surgery • Dental care (adult)	• Long-term care • Infertility treatment • Routine foot care	• Weight loss programs • Acupuncture • No coverage provided outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Oxygen • Chiropractic care	• Hearing aids • Routine eye care (adult, child)	• Private-duty nursing (when medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa.healthreform, or U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Denver Health Medical Plan, Inc. at 1-800-700-8140 or www.denverhealthmedicalplan.org, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol/gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 303-602-2100 / 1-800-700-8140.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 303-602-2100 / 1-800-700-8140.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 303-602-2100 / 1-800-700-8140.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 303-602-2100 / 1-800-700-8140.

––––––––––––––––––––To see examples of how this plan might cover costs for a sample medical situation, see the next section.––––––––––––––––––––

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $0
- Specialist copayment $30 copay
- Hospital (facility): $200 copay
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(laboratory)*

Total Example Cost	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$310
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$370**

Managing Joe's Type 2 Diabetes
(A year of routine in-network care of a well- controlled condition)

- The plan's overall deductible: $0
- Specialist copayment $30 copay
- Hospital (facility): N/A
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including diabetes education)*
Diagnostic tests *(blood work)*
Prescription drugs *(preferred generic by mail)*
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$230
Coinsurance	$446
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$731**

Mia's Simple Fracture
(In-network emergency room visit and follow up care)

- The plan's overall deductible: $0
- Specialist copayment $30 per visit
- Hospital (facility): $400 copay
- Other coinsurance: 20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies, ambulance)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$7
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$187**

The plan would be responsible for the other costs of these EXAMPLE covered services. * *Values shown are estimates for services received at Denver Health.*

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.

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