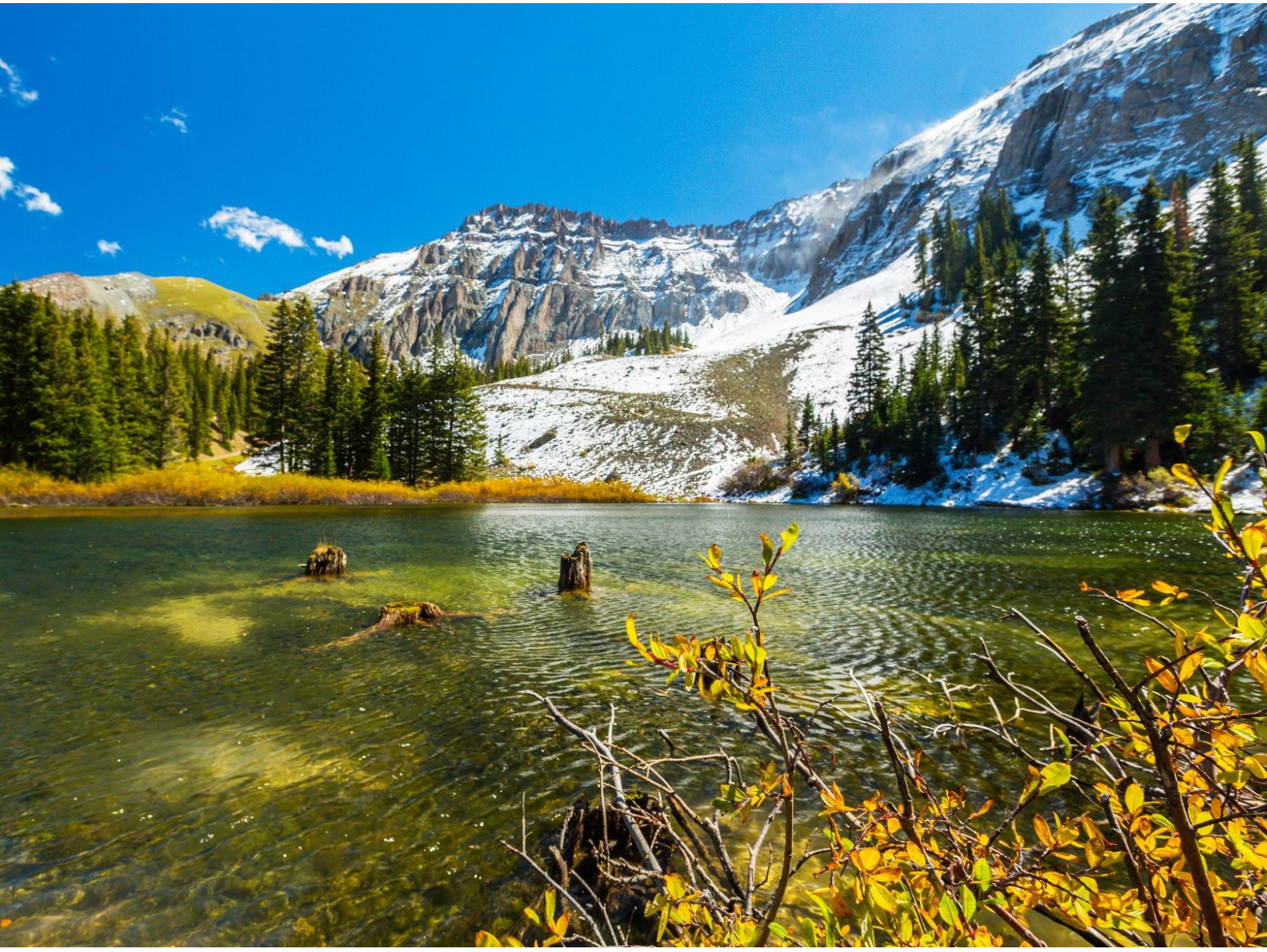
Benefits Decision Guide 2023



You & Your Benefits

A partnership for good health

DENVER HEALTH
est. 1860
FOR LIFE'S JOURNEY

Welcome

Providing great benefit choices to you and your family is just one of the many ways we support the physical, financial, and emotional well-being of the people who make our company successful — you.

Your Benefits

We recognize how important benefits are to you. That's why we're committed to supporting your overall wellness with a comprehensive benefits program designed to meet your unique needs. Key features of your benefits include:

- Choice among many popular benefit options.
- Effective and affordable health care coverage.
- Programs to help ensure financial security for you and your family.

Take Action

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 2023 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. Benefits will start the first of the month after your date of hire or qualifying life event.

Who Can Enroll?

- Full-time employee who regularly work between 30 and 40 hours a week. (.75 - 1.0 FTE)
- Part-time employee who regularly 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 child 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.*

*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. A notarized statement from family members is not sufficient to establish a legal guardianship.

Effective Date of Coverage

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 2023 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. Benefits will start the first of the month after your date of hire or qualifying life event or status change.

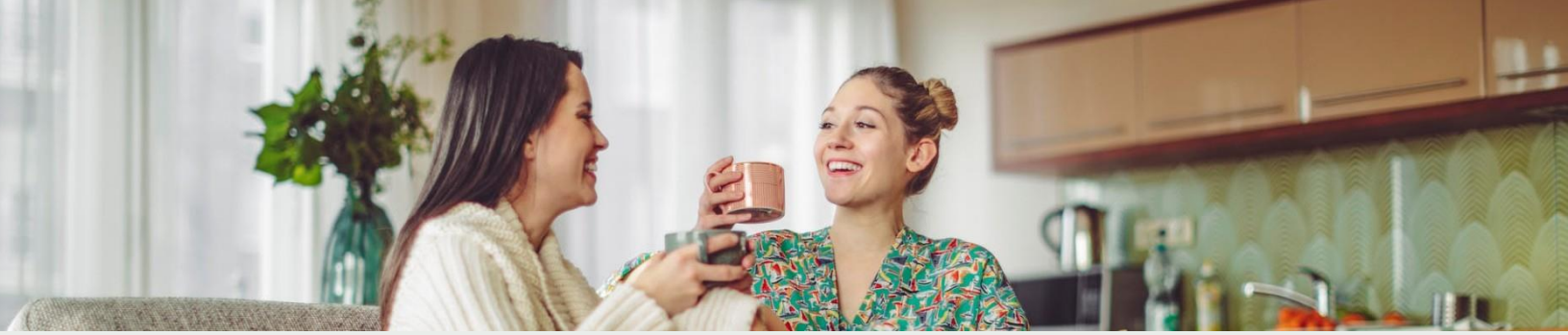
Dependent Information

It is your responsibility to notify the Benefits Center within 30 days of a change in eligibility, including a birth, death, divorce or loss of coverage elsewhere. Employees are required to provide documentation verifying any Qualified Life Event. Dependents aging out of the plan will automatically be removed from benefits at end of month in which they reach age 26. If coverage is lost a COBRA notice explaining their right to buy back their health care for up to 18 or 24 months, depending on the circumstances, will be mailed within 14 days from loss of coverage.

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.

Additional Questions?

Contact the HR Employee Benefits Center at 303-602-7072.



Inside this guide

Important Reminders

- **Update your Address and Phone** - In order to ensure you receive your updated insurance card and information, please make sure your contact information is up to date in the HRIS system. Making an address change in the HRIS system will update the following areas: Payroll, Benefits, HR, Accounts Payable, and benefit vendors (Fidelity, DHMP, Delta Dental, and VSP). Details on how to make updates can be on found on the Pulse.

Check out Perkspot for exclusive discounts

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. Visit PerkSpot at denverhealth.perkspot.com to create a personal account.

Qualified Life Events

Important information

- A Qualifying Life Event does not allow you to make plan-to-plan changes.
- You are required to provide the listed documentation within 30 days from the event date.
- If changes are not made within the 30-day window, open enrollment will be your next opportunity to change your benefits.

When Can I Change My Benefits?

You may change your benefit elections during the annual open enrollment period or if you experience a Qualifying Life Event as defined by the IRS during the plan year. If you experience a Qualifying Life Event and wish to change your benefits as a result, please submit a ticket on Cherwell at https://dhha.cherwellondemand.com or contact the Benefits Center at 303-602-7072.

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. Cannot switch plans.
Common Law Marriage	Affidavit of Common Law Marriage	
Registration of Domestic Partnership	Affidavit of Domestic Partnership or state registry	
Colorado Civil Union	Affidavit of Domestic Partnership or state registry	
Legal Separation	Legal Separation Order	Allows for removal of all ineligible dependents from current plans. Allows employee to enroll if lost coverage during a qualifying life event. Can 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 new dependent to existing plans. Can 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	
Gaining other coverage through a spouse's Open Enrollment	HIPAA Certificate, COBRA Notice or Letter from Spouse's Previous Employer*	Can drop coverage if gaining coverage through a spouse. Can add spouse and dependent children to health, dental and vision benefits. Can change FSA election or amount. Must provide proof of coverage lost in last 30 days.
Termination or Commencement of Spouse's Employment		
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. Employees moving from FT to PT position may remove dependents or drop coverage.
Dependent Reaching Ineligible Age	No documentation required	Remove ineligible dependents. Can change FSA election or amount.
Medicare Eligibility for You or Your Spouse	Proof of Medicare Eligibility must be within 60 days	Can opt out of health, dental, and vision benefits. Can 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 or insurance carrier. 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.

Health Benefits

Our employee benefits plan provides support for you and your family. We want you to know that you are not alone. Below is a summary of services available to you, many of which are also available to your family. We encourage you to take advantage of these services if you or a family member needs support. Please submit a ticket on Cherwell at https://dhha.cherwellondemand.com or contact the Benefits Center at 303-602-7072.

Medical

Denver Health employees can obtain plan materials for the health plans by reaching out to the Denver Health Medical Plan directly at **303-602-2100** or **DHMPmemberservices@dhha.org**, or visiting the Denver Health Medical Plan website at www.denverhealthmedicalplan.org/denver-health-and-hospital-authority-dhha. It is important for you to carefully review all the plan literature and member resources

About Our Networks

Denver Health provides you with three different medical plan options with different networks under the Denver Health Medical Plans (DHMP). Employees who choose the Denver Health Medical Care HMO plan 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 main campus and clinics)
- HighPoint HMO (Denver Health, University of Colorado, SCL Front Range (Denver area locations), and Children's Hospital and affiliated network providers)
- HighPoint POS (Denver Health, University of Colorado, Children's Hospital, SCL Front Range (Denver area locations), 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/provider-forms-and-materials.

For questions about prior authorization, please call Health Plan Services at 303-602-2100 or toll-free at 1-800-700-8140 (TTY/TDD users should call 711) Monday-Friday between 8am – 5pm MST.

Which plan is right for you?

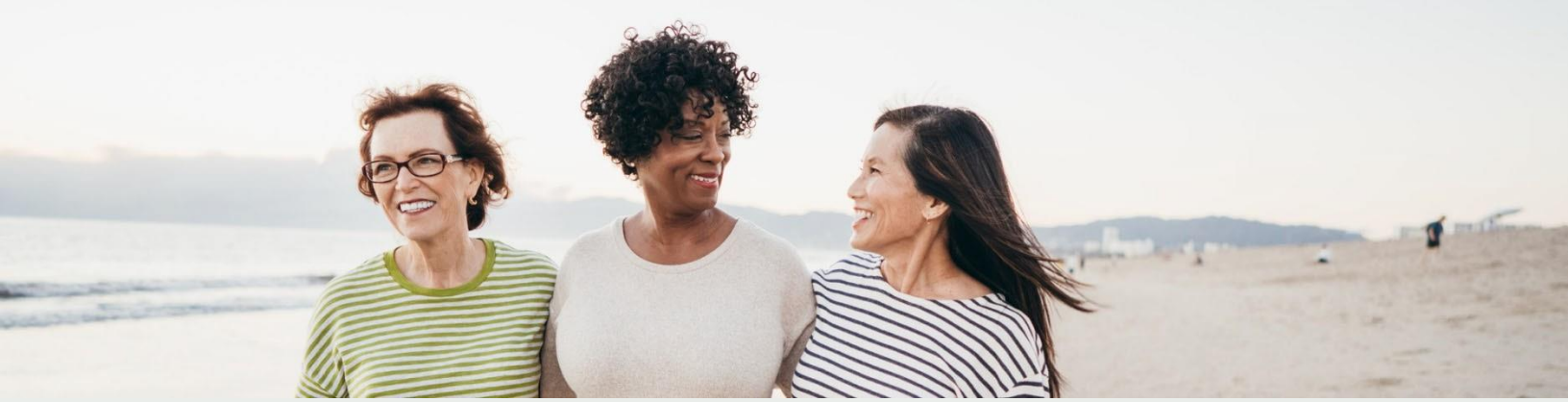
DHHA Medical Care HMO	Most cost-effective option; good choice if you plan to use the Denver Health Network and Services.
HighPoint HMO	Broader choice when selecting providers; good option if you live outside of the Denver area and use UC Health or SCL Front Range.
HighPoint POS	Maximum choice when selecting providers; good option if you or your dependents live out of the Denver area.

Medical Plan Costs

You and DHHA share the cost of your medical benefits — DHHA pays a generous portion of the total cost and you pay the remainder. The amount you pay is deducted from your paycheck. Your specific cost is determined by the plan you choose and the coverage level you select.

NEW VIRTUAL MENTAL HEALTH BENEFIT THRU DHMP

Elevate Mind is a new virtual mental health benefit available to Denver Health Medical Plan (DHMP) members. Licensed therapists and psychologists are available to help 24/7 for video or telephonic visits. These professionals have been hand-selected, U.S. trained, and board certified to deliver the best care to you and your family.



Medical Plan Comparison

The chart below provides a comparison of key coverage features and costs of DHHA's 2023 medical plan options.

	DHHA Medical Care HMO	HighPoint HMO	HighPoint POS	
	In-network	In-network	In-network	
Annual Deductible				
Per person/per family	No Deductible	$100 / $200	$500 / $1,000	
Out-of-pocket maximum				
Per person/per family	$4,350 / $8,700	$5,000 / $10,000	$5,000 / $10,000	
Medical coverage				
Doctor's office visits	$25 Copay	$35 Copay	$30 Copay	
Preventive care	100% Covered	100% Covered	100% Covered	
Specialist visits	$30 Copay	$40 Copay	$40 Copay	
Behavioral Health office visits	$15 Copay	Deductible and $25 Copay	$30 Copay	
Nurse line	100% Covered	100% Covered	100% Covered	
Outpatient surgery	$200 Copay	$400 Copay	Deductible and 20% coinsurance	
Inpatient hospital	$400 Copay	$600 Copay	Deductible and 20% coinsurance	
Emergency room	$150 Copay	$150 Copay	$150 Copay	
Labs and X-rays	$0 Copay	$0 Copay	Deductible and 20% coinsurance	
Retail prescription drug copays				
	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

Employee Medical Premiums –Cost Per Pay Period

*Premiums taken from 24 of your 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	$43.86	$43.86	$111.65	$111.65	$153.16	$153.16
Employee + Spouse	$93.13	$93.13	$237.11	$237.11	$324.21	$324.21
Employee + Child(ren)	$78.17	$78.17	$199.01	$199.01	$273.56	$273.56
Employee + Family	$129.36	$129.36	$329.33	$329.33	$442.83	$442.83

*0.75 to 1.0 FTE is considered Full-Time for benefits

**0.5 to 0.74 FTE is considered Part-Time for benefits

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 membership is required to access the fitness center. Email at fitness.center@dhha.org

Flexible Spending Accounts (FSAs)

Benefit-eligible employees may choose to participate in Flexible Spending Accounts (FSA) through WEX benefits for the 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 pre-tax basis. Eligible employees can only enroll in a FSA account during open enrollment, as a new hire, or a qualifying life event. Coverage effective date begins first of the month following the qualifying life event.

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 pre-tax 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 pre-tax payroll deduction.
- To create and access your online flexible spending account visit www.wexinc.com or call 866-451-3399 to view your balance and account and activity, file a claim and upload documents, etc.

Health Care FSA

The Health Care Flexible Spending Account allows employees to set aside a minimum of $240 up to $3,050 pre-tax dollars per calendar year per employer for reimbursement for some usual and customary out-of-pocket health care costs of the employee, spouse, and qualified dependents.

Visit www.wexinc.com/insights/benefits-toolkit/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. 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 FSA

The Dependent Care Flexible Spending Account (Dependent Care FSA) allows employees to set aside a minimum of $240 up to $5,000 **per household per calendar year** on a pre-tax basis for reimbursement for dependent care (childcare) costs. Dependent Care FSA eligible expenses include:

- Care for children ages 12 and younger who are claimed as qualified dependents on your tax return
- 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 dependent person is a qualifying individual
- In case of services provided outside your household, the person still regularly spends at least 8 hours each day in your household

WEX Benefits Mobile App - Access your FSA benefits anytime, anywhere

Access your benefits on the go 24/7 with the WEX benefits mobile app. Our free app gives you convenient, real-time access to all your benefits accounts in one spot. This makes it easy to use your hard-earned dollars and view recent account activity without ever needing to call in. The benefits mobile app keeps your benefits always within reach. Want to know the status of a recent claim or easily check the balance of your accounts? Log in to the secure app to get answers to those questions and so many more — wherever and whenever you want.

**Current IRS limits; the plan year limits may not have been available when this guide was printed.*

Dental Benefits

Delta Dental

Denver Health offers three dental plans through Delta Dental of Colorado. 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. You can search for dentists at www.deltadentalco.com.

Delta Dental Providers

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

- Core Plan EPO 3C; This plan utilizes dentists from the EPO/PPO Provider list. You can also search for dentists at www.deltadentalco.com.
- Preferred Plan EPO 1B: This plan also utilizes the EPO/PPO Provider list. You can search for dentists at www.deltadentalco.com.
- Premier Plan PPO+ Premier: 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.

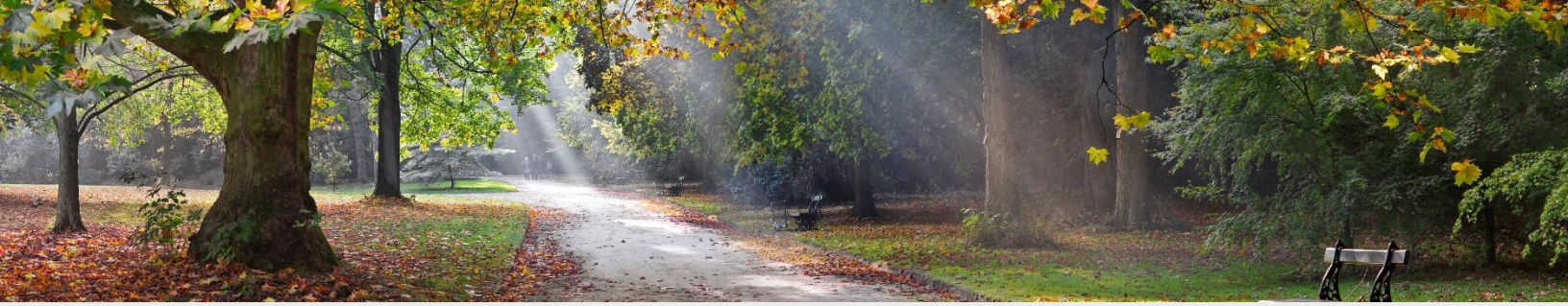
Delta Dental can cover specific questions about services. You may reach them at 800-610-0201. You can also search for dentists at www.deltadentalco.com.

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

Which plan is right for you?

Core Plan EPO 3C	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.
Preferred Plan EPO 1B	This plan provides more comprehensive coverage for your restorative and orthodontic needs. This plan is a copay system, with lower copays than the Core EPO 3C plan.
Premier Plan PPO+ Premier	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. Adult orthodontic coverage is not offered under Delta PPO Premier Plan. This is the only option that covers dental implants.



Dental Plan Comparison .

Service/Procedure Guide	Core Plan EPO 3C	Preferred Plan EPO 1B	Premier Plan PPO+ Premier	
Dentist Choice	EPO/PPO List	EPO/PPO List	No Restrictions	
Services				
Bitewing, single film (D0270)	$0 copay	$0 copay	90% covered	
Cleaning (D1110 & D1120)	$0 copay	$0 copay	90% covered	
Exam Fee	$10 copay	$10 copay	N/A	
Amalgam Filing (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	
Maximum Deductible				
Annual Deductible	None	None	$25	$60
Annual Maximum Benefit	$2,000*	$2,000*	$1,100*	$100

*Annual maximum does not include orthodontic benefit.

**Restrictions apply for children

Employee Dental Premiums – Per Pay Period

*Premiums taken from 24 of your 26 Bi-Weekly Paychecks

	Core Plan EPO 3C		Preferred Plan EPO 1B		Premier Plan 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 to 1.0 FTE is considered Full-Time for benefits

**0.5 to 0.74 FTE is considered Part-Time for benefits

Vision Benefits

Your Coverage with an In-network VSP Provider			
	Description	**Coverage**	**Frequency**
Well Vision Exams	Focuses on your eyes and overall wellness	$15 copay	Every calendar year
Prescription Glasses	One benefit per family member	$15 copay	See frames and lenses
Frame	• $150 allowance for a wide selection of frames • $170 for featured frame brands • $80 allowance at Costco & Walmart • 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 • Impact resistant lenses for dependent	Included in prescription glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses	$0 $95-$105 $150-$175	Every calendar year
Contacts (instead of Glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60 allowance	Every calendar year
Diabetic Eye Care Plus Program	• Retinal screening for members with diabetes • Additional exams and services for members with diabetic eye disease, glaucoma, or age-related macular degeneration. Limitations and coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20	As needed

Extra Savings Available Through Vision Plan

Retinal Screening

- No more than a $39 copay on routine retinal screening as an enhancement to a Well Vision 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.

*Please note: For two party coverage, frame allowance will apply every 24 months, even if covered dependent changes. This plan can be used in conjunction with the DHMP vision benefits.

Vision Premiums

*Premiums taken from 24 of your 26 Bi-Weekly Paychecks

Vision Plan	
Coverage	Per pay period
Single	$3.02
Two Party*	$6.04
Family	$9.72

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

Life Insurance and Accidental Death & Dismemberment

Unum provides Denver Health with Group and Voluntary Life & Accidental Death & Dismemberment (AD&D) insurance that can be purchased in addition to the Basic Life plan that Denver Health provides for employees.

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 time their annual salary for each policy. 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. 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 a covered 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.

Voluntary Life Insurance and AD&D

Eligible employees can apply 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. Coverage up to a guaranteed amount of $250,000 is available for the employee and $50,000 for their spouse without having to answer medical questions. Eligible employees can only enroll during open enrollment, as a new hire, or during other special events throughout the year which will be communicated by the Denver Health Benefits Center. 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.

What is AD&D Insurance?

Should you lose your life, sight, hearing, speech, or use of your limb(s) in an accident, AD&D provides additional benefits to help keep your family financially secure. AD&D benefits are paid as a percentage of your coverage amount — from 50% to 100% — depending on the type of loss.

Disability Plans

Disability Insurance

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 takes effect the first of the month after your date of hire. LTD takes effect the first of the month 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 in a 0.5 FTE or greater.

10% STD Buy-Up Option

How to Enroll: Eligible employees have the option to purchase additional 10% buy-up STD coverage that replaces up to 70% of weekly earnings up to a maximum weekly amount of $3,800. Employees pay for the cost* of the buy-up through payroll deduction. Employees can enroll in the STD buy-up option during Open Enrollment or as a new hire. *Cost is dependent on salary, please contact the Benefits Center for more details.

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.

Long-Term Disability (LTD)

Long-Term Disability insurance helps replace a portion of your income if you are 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. Denver Health provides this coverage, 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.

Enhanced Voluntary Benefits

Accident Insurance

Eligible employees can purchase Accident Insurance from Unum at discounted rates through payroll deductions. When you suffer an accident such as a burn or broken bone, Accident Insurance provides a lump-sum cash benefit based on your injury(s) and the treatment you receive. These benefits are paid on top of what your health insurance covers and can be used at your own discretion. **Eligible employees can enroll during open enrollment, your new hire period, or a qualifying life event.**

Critical Illness Insurance

No one can be completely prepared when a critical illness strikes, but if you or a loved one is diagnosed with a covered condition such as cancer, stroke, or heart attack, Critical Illness Insurance from Unum provides a lump-sum cash benefit to help pay for out-of-pocket medical expenses or any other bills that need attention, including rent or groceries. **Eligible employees can enroll during open enrollment, your new hire period, or a qualifying life event.**

Legal Plan

Eligible employees can enroll in MetLife legal plans for access to experienced attorneys to help with estate planning, home sales, tax audits and more. For a monthly premium of $17.50 conveniently paid through payroll deduction, you, your spouse, and dependents get legal assistance for some of the most frequently needed legal matters. **Eligible employees can only enroll during open enrollment, your new hire period, or a qualifying life event.**

NEW! Hospital Indemnity

A sudden hospital stay can bring big bills. You might be surprised by how quickly deductibles or co-payments can add up. Then there are other bills like the mortgage, electricity, and car payments that keep coming -- even if you're not able to work due to a hospital stay. As a Denver Health employee, you can set up a special safety net with cash benefits to help you cover those types of bills when you're in the hospital. Eligible employees can enroll during open enrollment, your new hire period, or a qualifying life event.

Available Year-Round

Home and Auto

Eligible employees can enroll in Farmers Group Select discounted Auto, Homeowners and Renters insurance through convenient payroll deductions. Could you save on your auto insurance this year? Most experts suggest you review your coverage annually to make sure you're getting the best rate and coverage. Eligible employees can enroll in this benefit anytime during the year.

Pet Insurance

You care about your pets and consider them members of your family. Pet insurance is offered through Nationwide and provides coverage for a wide range of veterinary services, such as wellness visits, vaccinations, surgical procedures, medical care following accidents and illnesses, and more Eligible employees can enroll in this benefit anytime during the year.

Learn more about enhanced Voluntary Benefits

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.

Reminder to plan your PTO!

Don't wait until the end of the year! Find your current PTO balance by visiting this link: https://mingle-portal.inforcloudsuite.com/DENVERHEALTH_PRD/

Paid Time Off (PTO) Accrual Rates for 1.0 FTE			
Completed Years of Services	**Annual Accrual**	**Maximum Carry Over Hours**	**Maximum Hours**
0 to 4 years	160 hour 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

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. Please contact the Leave of Absence (LOA) team to discuss your options at 303-602-7007.

*Restrictions apply.

DHHA Observed Holidays	
New Year's Day (observed)	Monday, January 2nd
Martin Luther King Day	Monday, January 16th
Memorial Day	Monday, May 29th
Independence Day	Tuesday, July 4th
Labor Day	Monday, September 4th
Thanksgiving Day	Thursday, November 23rd
Christmas Day	Monday, December 25th

Retirement Plans

Denver Health is pleased to offer a comprehensive retirement program options. 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

401(a) Defined Contribution Plan and Trust

(Social Security Replacement Plan)

This is a mandatory defined plan that cannot be modified, in which you are automatically vested. 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.

401(a) Enhanced Retirement Provision

Employees who are 0.5 FTE and above are eligible for the additional 3% contribution to the Social Security Replacement Plan, Denver Health contributes an additional 3% (up to IRS limits) on behalf of all benefit-eligible employees, except Denver Employees Retirement Program (DERP) participants. These contributions are 100% vested after 3 years of employment with Denver Health.

457(b) Deferred Compensation Plan

(Voluntary Retirement Savings Plan)

Denver Health offers this voluntary retirement plan that allows employees to invest more pre-tax or after-tax (Roth) dollars. 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%.**It may take up to two pay cycles for the auto-enrollment process to activate and for any modifications to take effect.**

Denver Health's matching contribution is subject to the 3-year vesting schedule. Other percentage limits of compensation will apply.

Fidelity Investments is Denver Health's retirement plan vendor. A variety of Fidelity options are available to meet your investment needs. 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/reserve.

Contribution Type	Who Makes the Contribution?	How Much is the Contribution?
Mandatory Contributions (12.2%) made by you and Denver Health into your 401(a) Plan		
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 IRS limit
Denver Health Matching Contribution* (made into your 401(a) Plan account)	Denver Health	Dollar-for-dollar match up to 3.5% of you eligibly pay

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

Employee Well-being Benefits and Perks

Physical, Financial, Mental, Social Well-being

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.

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 except for stepchildren already in the custody of a biological parent. Please submit a ticket on Cherwell at https://dhha.cherwellondemand.com or contact the Benefits Center at 303-602-7072.

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 membership is required to access the fitness center. Email fitness.center@dhha.org or visit the Pulse to enroll.

Elevation Fitness Portal

All Denver Health employees have access to our free Elevation Fitness Portal. Elevation Fitness is a free virtual fitness membership offering live and on-demand fitness classes and video library, wellness workshops and podcasts. Visit elevationportal.com and click “Sign Up”.

Learn More

For more information refer to the Well-being Subsite on the Pulse

Healthy Hospital Initiative

Our Healthy Hospital efforts aim to provide patients, visitors, and staff with a supportive and healthy environment. Denver Health is continuously improving the nutritional environment by way of healthier food, beverages, promotions, and breastfeeding support and amenities to create a culture that promotes health and well-being. Denver Health is proud to be recognized by the Colorado Healthy Hospital Compact as a Platinum level hospital, the highest achievement. The Compact 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. Visit PerkSpot at denverhealth.perkspot.com to create a personal account.

RTD Eco Pass

All Denver Health and CSA employees in a 0.5 FTE or higher are eligible to receive an RTD EcoPass. Employees may enroll for the EcoPass at any time during the calendar year. Submit a Cherwell request to HR Benefits to enroll. 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

myStrength

Recharge, refresh and improve your mood with myStrength. All Denver Health employees have free access to myStrength’s web and mobile tools to support your goals and well-being. Learning to use myStrength’s tools can help you overcome the challenges you face and stay mentally strong. Visit www.mystrength.com and click on “Sign Up”; use access code DHHAemployees.

Employee Well-being Benefits and Perks cont.

Health Advocate Employee Assistance Program (EAP)

Health Advocate provides our Employee Assistance Program (EAP) benefit and the Health Advocate Call Center. The Health Advocate Call Center representatives are available from 6 AM to 6 PM MST for benefit questions. Health Advocate can assist you with:

- Questions about your benefit choices and options
- Finding a doctor, scheduling an appointment or prior authorizations

Health Advocate EAP is available 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, legal, or financial questions. EAP services are available 24 hours a day/ 7 days a week.

- 5 counseling sessions per incident, per family member, per year at no charge to you. Every effort will be made to match you with an in-network provider should you chose to continue treatment after your initial 5 visits.
- All calls and services are confidential
- Call 866-799-2691 or go to HealthAdvocate.com/members, Email at answers@HealthAdvocate.com or use the Health Advocate mobile app.

RESTORE: Resilience and Equity through Support and Training for Organizational Renewal (*formerly RISE)*

Look for changes coming soon!

Denver Health RISE is rebranding to RESTORE Fall 2022. It will continue to be a healthcare-based peer support program developed by Johns Hopkins and customized to meet the needs of our institution. Peer Responders are available 24/7 to provide immediate, confidential peer-to-peer support to all personnel who experience distress while at work. Call 303-436-7473 or email DHRISE@dhha.org.

Behavioral Health & Substance Misuse Treatment

Dealing with behavioral health issues or substance misuse can be stressful for you and your family. Your medical plan pays for treatment both inside and outside of the Denver Health System. For outpatient office visits, you can schedule an appointment with either a Denver Health or Cofinity provider directly without a prior authorization. When you are ready for more help, such as an inpatient, residential or an intensive outpatient program, work with either your primary care doctor or your behavioral healthcare provider to obtain a prior authorization from the Denver Health Medical Plan. If you need time away from work to obtain treatment, you may be eligible for a leave of absence and a portion of your income may be replaced while you are getting well. Please contact the Leave of Absence (LOA) team to discuss your options at 303-602-7007.

WorkLife Partnership

Denver Health partners with WorkLife Partnership to provide resources and assistance to help you and your family one generation up and one generation down, overcome work-life challenges. WorkLife services are always free and confidential. WorkLife Navigators are Community Resource Specialists who can help you with:

- Small Dollar Loan from $400 to $1,000. No credit check, no interest, 12-month repayment trough Payroll deductions.
- Support for transportation
- Finding resources for affordable childcare
- Budgeting and financial wellness and small dollar loan options
- Accessing food pantries
- Accessing resources for housing
- Connecting with mental behavioral health resources

Resource Navigator landing page:
https://www.askthenavigator.org/

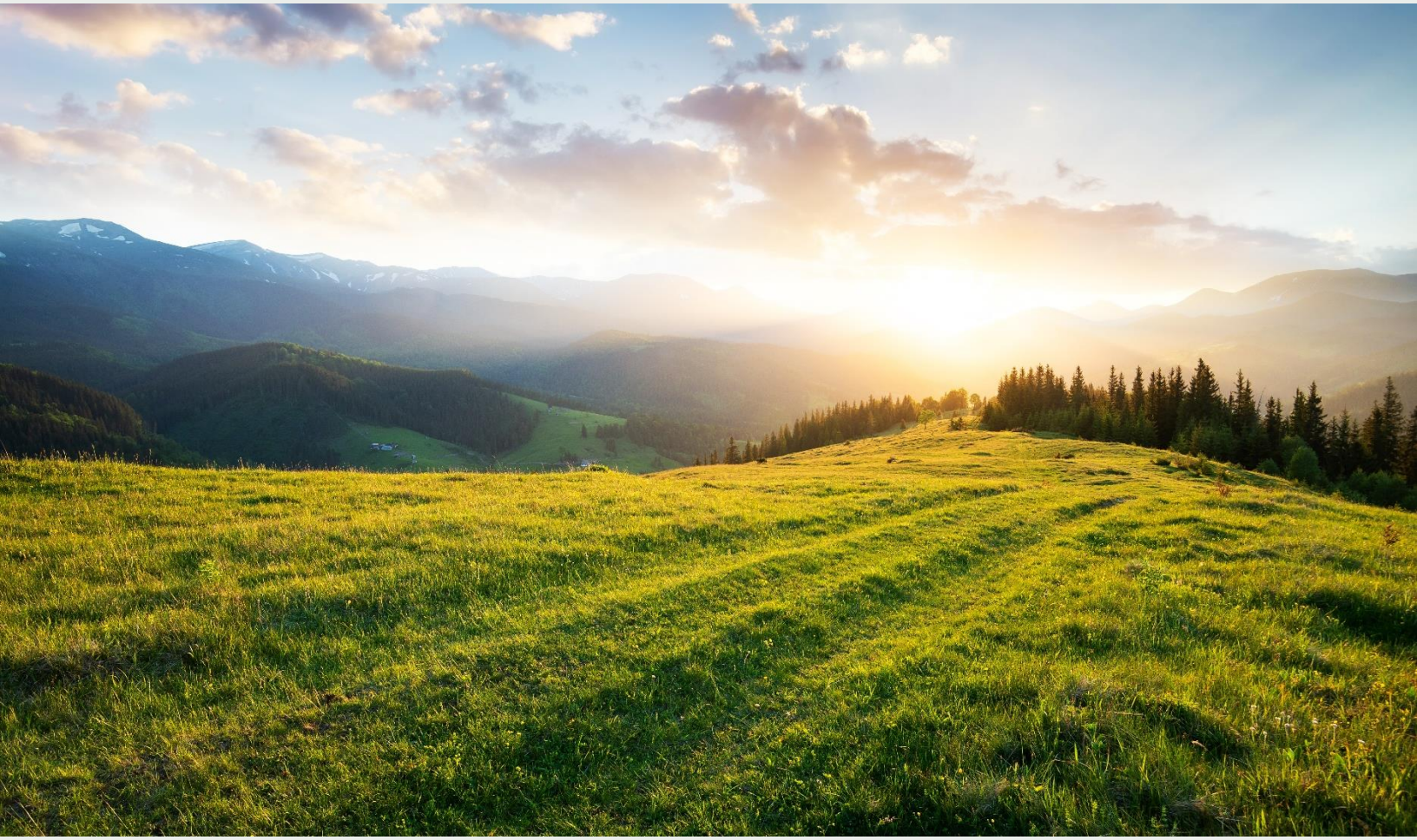
Call: 888-219-8993; Text NAVIGATOR to 888-219-8993;
Email navigator@worklifepartnership.org

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.

Learn More For additional information, visit the Pulse and review the current tuition reimbursement policy

The Tuition Reimbursement benefit supports formal academic education taken at accredited colleges and universities. Its purpose is to promote skill and career development; while also increasing employee's retention and satisfaction by providing financial support for educational pursuits. However, Denver Health makes no guarantee that participation in this program entitles the employee to advancement, a different job assignment, or a pay increase.



Important Contacts

Denver Health and Hospital Authority
HR Employee Benefits Center
Mail Code 0115

Benefit Line: 303-602-7072

Submit a ticket: CHERWELL TICKET system located on the Benefits site on the Pulse.

Company	Phone Number	Website/Email
Career Service Authority Benefits (City employees)	720-913-5697	www.denvergov.org/Home benefits@denvergov.org
Delta Dental of Colorado	1-800-610-0201	www.deltadentalco.com customer_service@ddpco.com
Denver Health Appointment Line	303-436-4949	Mychart.denverhealth.org/mychart/openscheduling
Denver Health Medical Plan	303-602-2100	www.denverhealthmedicalplan.org DHMPmemberservices@dhha.org
DERP (Denver Employee Retirement Plan)	303-839-5419	www.derp.org help@DERP.org
Dispatch Health (Urgent Care House Calls)	888-908-0553	www.dispatchhealth.com
Fidelity Investments (401(a) & 457(b))	800-343-0860	http://www.fidelity.com/atwork
Health Advocate EAP Services	1-866-799-2691	https://members.healthadvocate.com/Account/OrganizationSearch
Nurse Advice Line	303-739-1211	www.denverhealth.org/patients-visitors/nurseline
Unum (Life Insurance & AD&D, Long Term Disability)	800-421-0344	www.unum.com
Vision Service Plan	800-877-7195	www.vsp.com
Voluntary Benefits (Critical Illness, Accident, Hospital Indemnity, Legal, Pet and Home and Auto)		
WEX (Flexible Spending Accounts)	866-451-3399	www.wexinc.com customerservice@wexhealth.com

Important notices

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act of 1998 (WHCRA) is a federal law that provides protections to patients who choose to have breast reconstruction in connection with a mastectomy. If WHCRA applies to you and you are receiving benefits in connection with a mastectomy and you elect breast reconstruction, coverage must be provided for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of all stages 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.

Insurance Marketplace Coverage Options

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 9.61% of your household income for 2022, 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 www.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 www.askebsa.dol.gov or call 866- 444-EBSA (3272).

Medicaid and CHIP contact info:

Health First Colorado Website:
https://www.healthfirstcolorado.com/
1-800-221-3943/ State Relay 711

CHP+:www.colorado.gov/pacific/hcpf/
child-health-plan-plus
1-800-359-1991/ State Relay 711

Health Insurance Buy-In Program
(HIBI):
https://www.colorado.gov/pacific/hcpf/
health-insurance-buy-program
1-855-692-6442

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 2023. 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 2023 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 . 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 POS

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) or visit the program online at https://www.shiptacenter.org/
- 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 Center
601 Broadway – 5th Floor, MC 0115,
Denver, CO 80204
303-602-7072

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! I**n 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 ensure the notification form has been received.

Secondary Event Extension - Another extension of the 18 or above mentioned 29-month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement (under Part A, Part B, or both), or a dependent child ceasing to be a dependent. A second event can only occur if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Continuation coverage will be extended to a maximum 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It will be the qualified beneficiary's responsibility to notify the plan administrator of a second event. Procedures for making proper and timely notice of a second event will be detailed in the election notice when a qualifying event occurs.

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

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

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

Notification of Address Change - In order to protect your group health insurance continuation coverage rights and to ensure all covered individuals receive information properly and efficiently, active employees are required to change their address on the Compass 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 Compass 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
303-602-7072

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 because 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 and 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 **303-602-7072**

ACA Section 1557 Notice, Statement and Taglines

For translated versions of the following ACA Section 1557 notices, please see the HHS website at www.hhs.gov/civil-rights/for-individuals/section-1557/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 not English, such as:

• Qualified interpreters

• Information written in other languages If you need these services, contact

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

MC 0115, Denver CO 80204
303-602-7072

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 Center
601 Broadway – 5th Floor,

MC 0115, Denver CO 80204
303-602-7072

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:

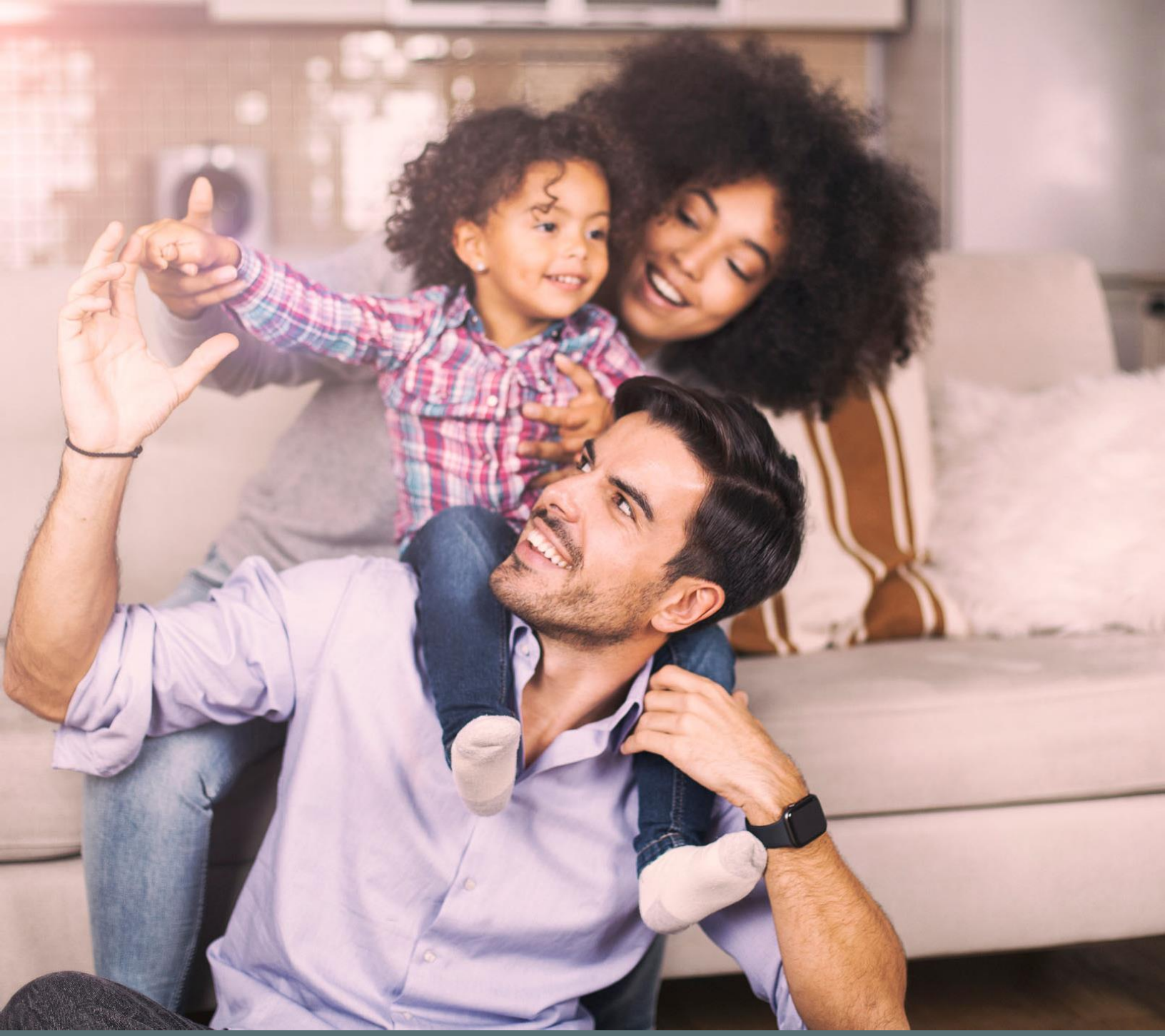
U.S. Department of Health and Human Services

200 Independence Avenue, SW Rom 509F, HHH Building Washington, D.C. 20211

1-800-368-1019 (800-537-7697 TDD)

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html



This guide is intended to describe the eligibility requirements, enrollment procedures, plan highlights, and coverage effective dates for the benefits offered by Denver Health & Hospital Authority. It is not a legal plan document and does not imply a guarantee of employment or continuation of benefits. While this guide is a tool to answer many of your benefit questions, full details of the plans are contained in the Summary Plan Descriptions (SPDs), which govern each plan's operation. The noted plan changes in this guide may service as a Summary of Material Modifications (SMM) to the SPD. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will prevail.