2020 INSURANCE AGREEMENT
DENVER HEALTH MEDICAL PLAN, INC.

THIS AGREEMENT to purchase insurance policies is made between the **CITY AND COUNTY OF DENVER**, a municipal corporation of the State of Colorado (the "**Subscribing Group**" or "**City**") and Denver Health Medical Plan, Inc., a Colorado nonprofit corporation affiliated with the Denver Health and Hospital Authority, a body corporate and political subdivision of the State of Colorado (the "**Insurance Company**" or "**DHMP**" and jointly "the parties").

The parties agree as follows:

1. COORDINATION AND LIAISON: Insurance Company shall fully coordinate the purchase of agreed policies with the Executive Director of the Office of Human Resources or the Executive Director's designee ("**Executive Director**").

a. The Executive Director shall be the authorized representative to sign the final insurance policies, the attached Exhibits, and any other documents necessary to effectuate the policy-related documents, and implement the administration of the approved plan design and coverage the City desires to purchase.

2. SERVICES TO BE PERFORMED:

a. The insurance policy being purchased by the City requires approval by the Colorado Division of Insurance ("DOI"). If the insurance policy is pending DOI approval, the Summary of Benefits and Coverage ("SBC"), and Performance Guarantees document (collectively attached hereto and incorporated herein as "**Exhibit A**") are attached as evidence of the insurance policy coverage the City intends to purchase.

b. Upon receipt of the DOI-approved Evidence of Coverage (or Certificate of Coverage) the Executive Director shall file the DOI-approved insurance policy and Evidence of Coverage with the City's Clerk and Recorder to complete the public record for this Agreement.

c. Collectively, the above constitute the HMO Contract ("**HMO Contract**") between DHMP, and the City for the provision of health care benefits to eligible persons electing to enroll hereunder as Members. In the event of a conflict between the terms of the enrollment form and the terms of the applicable Member Handbook, the terms of the applicable Member

Handbook shall prevail.

d. Insurance Company will provide the City with all internal policies which affects Member coverage under this Agreement. These policies will be disclosed to the City prior to the effective date of this Agreement.

3. **TERM**: This Agreement will commence as of January 1, 2020, and will terminate at 11:59 p.m., on December 31, 2020 (the "**Term**"). The insurance policies listed in **Exhibit A** shall expire at the end of the Term.

4. **COMPENSATION AND PAYMENT**:

a. **Fee**: The City shall pay, and the Insurance Company shall accept as the sole compensation, the Maximum Contract Amount in monthly payments as required in the policies attached in **Exhibit A**, as full payment for the policies. Notwithstanding any other provision, if a policy is cancelled by the City prior to the end of the Term, the City shall be responsible to pay all pro rata amounts due through the end of the calendar month of termination.

b. **Reimbursable Expenses**: There are no reimbursable expenses allowed under this Agreement. Notwithstanding any term in the policy to the contrary and outside of the policy premium costs, the Insurance Company will not collect or attempt to collect any direct cost associated with the policies purchased by the City. Further, the Insurance Company agrees not to adjust the policy premiums at any time prior to the termination of this Agreement.

c. **Maximum Contract Amount**:

(1) Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed **NINE MILLION EIGHT HUNDRED THOUSAND AND 00/100 DOLLARS ($9,800,000.00)** (the "**Maximum Contract Amount**") for the policies. The City is not obligated to execute an Agreement or any amendments for any further services. Any services performed beyond those in **Exhibit A** are performed at Insurance Company's risk and without authorization under this Agreement.

(2) The City's payment obligation, whether direct or contingent, extends only to funds appropriated annually by the Denver City Council, paid into the Treasury of the City, and encumbered for the purpose of the Agreement. The City does not by this Agreement irrevocably pledge present cash reserves for payment or performance in future fiscal years. The

Agreement does not and is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the City.

d. **Monthly Premiums**. The undersigned Subscribing Group shall pay the monthly premiums to DHMP.

e. **Monthly Processing Dates**: Monthly premiums are due ("Premium Due Date") on the last day of the calendar month for which premiums are due. A payment grace period of ten (10) days past the Premium Due Date is allowed for payment to be received.
All Payments should be sent to:

Denver Health Medical Plan, Inc.
777 Bannock Street, MC 6000
Denver, Colorado 80204
Attn: Manager of Finance

f. **Notice of Enrollments**. The Subscribing Group shall notify DHMP of enrollments, terminations or other changes within sixty (60) days. DHMP will not accept retroactive additions or terminations after sixty (60) days. No adjustment in premium(s) or coverage shall be granted by DHMP to the Subscribing Group for more than sixty (60) days of coverage prior to the date DHMP was notified of the change.

5. **STATUS OF INSURANCE COMPANY**: The Insurance Company is an independent contractor. Neither the Insurance Company nor any of its employees are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code, or for any purpose whatsoever.

6. **TERMINATION**:

a. The City has the right to terminate this Agreement and any policy listed in **Exhibit A**, or all policies, with or without cause upon thirty (30) days prior written notice to the Insurance Company.

b. Upon termination the Insurance Company shall have no claim against the City by reason of, or arising out of, incidental or relating to termination, except for compensation due under a policy for the month of termination.

c. The HMO Contract may be terminated by the Subscribing Group on the

anniversary of the Effective Date, upon thirty (30) days' advance written notice to DHMP or the first to occur of the following:

d. At any time by order of the Colorado Commissioner of Insurance;

e. By DHMP, at any time, ten (10) days after the date of the cancellation notice pursuant to Paragraph 4. Coverage will continue through the end of the period for which premiums have been paid;

f. By DHMP, upon thirty (30) days advance written notice, if any underwriting condition listed in Paragraph 6 is not being met;

g. By DHMP, at any time, upon thirty (30) days advance written notice, due to fraud or intentional misrepresentation of material fact on the part of Subscribing Group with respect to health benefit plan coverage;

h. By DHMP, upon the occurrence of any terminating event, and with such advance notices, as provided in Section 10-16-201.5 C.R.S., and applicable regulations, as the same may be amended from time to time, or successor statute or regulations of similar tenor and effect; or

i. By DHMP, should it discontinue to offer its large group health plans in accordance with C.R.S. §10-16-201.5(6).

Subscribing Group may renew coverage subject to underwriting conditions, the eligibility requirements, and the other terms and conditions of DHMP in effect at the time of renewal. Renewal is also subject to DHMP's right to discontinue offering its large group health plan and to the other terms and conditions contained or referenced herein.

7. **EXAMINATION OF RECORDS**: Any authorized agent of the City, including the City Auditor or his or her representative, has the right to reasonable access and the right to examine any pertinent books, documents, papers and records of the Insurance Company, involving transactions related to the Agreement, during reasonable hours and until the latter of three (3) years after the final payment under the Agreement or expiration of the applicable statute of limitations. Nothing in this provision shall require the Insurance Company to make disclosures in violation of state or federal privacy laws.

8. **WHEN RIGHTS AND REMEDIES NOT WAIVED**: In no event will any payment or other action by the City constitute or be construed to be a waiver by the City of any

breach of covenant or default that may then exist on the part of the Insurance Company. No payment, other action, or inaction by the City when any breach or default exists will impair or prejudice any right or remedy available to it with respect to any breach or default. No assent, expressed or implied, to any breach of any term of the Agreement constitutes a waiver of any other breach.

9. INSURANCE: Insurance Company is a "public entity" within the meaning of the Colorado Governmental Immunity Act, §24-10-101, et seq., C.R.S., as amended. Insurance Company shall maintain at all times during the term of this Agreement such liability insurance, by commercial policy or self-insurance, as is necessary to meet the Insurance Company's liabilities under the Act. Proof of such insurance shall be provided upon request by the City. This obligation shall survive the termination of this Agreement.

10. DEFENSE AND INDEMNIFICATION

a. Insurance Company shall, to the extent permitted by Colorado law, defend and indemnify the City with respect to any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred solely as a result of any of the following: Insurance Company's breach of this Agreement, from breach of any fiduciary responsibility that Insurance Company may have under applicable law, or as a result of other negligent act of Insurance Company which was the sole cause of the claim. This obligation to defend or indemnify does not extend to claims or causes of action against Insurance Company or City based in whole or in part on the acts, representations, or omissions of the City or other third party.

b. Insurance Company's obligation to defend and indemnify shall apply only to lawsuits in which both the City and Insurance Company are named defendants. In discharging its obligation to defend as set forth above, Insurance Company's counsel shall represent the interests of both Insurance Company and the City. With respect to any such lawsuit, Insurance Company shall keep the City informed of all significant developments and shall receive and consider any legal advice offered by the City. The City shall provide Insurance Company with reasonable notice of any actual or threatened action which may be indemnifiable pursuant to this Section.

c. Neither party waives any rights under the Colorado Governmental Immunity Act or any other provision of Colorado State law.

11. TAXES, CHARGES AND PENALTIES: The City is not liable for the payment of taxes, late charges or penalties of any nature, except for any additional amounts that the City may be required to pay under the City's prompt payment ordinance D.R.M.C. § 20-107, *et seq*. The Insurance Company shall promptly pay when due, all taxes, bills, debts and obligations it incurs performing the services under the Agreement and shall not allow any lien, mortgage, judgment or execution to be filed against City property.

12. ASSIGNMENT; SUBCONTRACTING: The Insurance Company shall not voluntarily or involuntarily assign any of its rights or obligations, or subcontract performance obligations, under this Agreement without obtaining the Executive Director's prior written consent. Any assignment or subcontracting without such consent will be ineffective and void, and will be cause for termination of this Agreement by the City. The Executive Director has sole and absolute discretion whether to consent to any assignment or subcontracting, or to terminate the Agreement because of unauthorized assignment or subcontracting. In the event of any subcontracting or unauthorized assignment: (i) the Insurance Company shall remain responsible to the City; and (ii) no contractual relationship shall be created between the City and any sub-Insurance Company, subcontractor or assign.

13. INUREMENT: The rights and obligations of the parties to the Agreement inure to the benefit of and shall be binding upon the parties and their respective successors and assigns, provided assignments are consented to in accordance with the terms of the Agreement.

14. NO THIRD PARTY BENEFICIARY: Enforcement of the terms of the Agreement and all rights of action relating to enforcement are strictly reserved to the parties. Nothing contained in the Agreement gives or allows any claim or right of action to any third person or entity. Any person or entity other than the City or the Insurance Company receiving services or benefits pursuant to the Agreement is an incidental beneficiary only.

15. NO AUTHORITY TO BIND CITY TO CONTRACTS: The Insurance Company lacks any authority to bind the City on any contractual matters. Final approval of all contractual matters that purport to obligate the City must be executed by the City in accordance with the City's Charter and the Denver Revised Municipal Code.

16. SEVERABILITY: Except for the provisions of the Agreement requiring appropriation of funds and limiting the total amount payable by the City, if a court of competent

jurisdiction finds any provision of the Agreement or any portion of it to be invalid, illegal, or unenforceable, the validity of the remaining portions or provisions will not be affected, if the intent of the parties can be fulfilled.

17. CONFLICT OF INTEREST:

a. No employee of the City shall have any personal or beneficial interest in the services or property described in the Agreement. The Insurance Company shall not hire, or contract for services with, any employee or officer of the City that would be in violation of the City's Code of Ethics, D.R.M.C. §2-51, et seq. or the Charter §§ 1.2.8, 1.2.9, and 1.2.12.

b. The Insurance Company shall not engage in any transaction, activity or conduct that would result in a conflict of interest under the Agreement. The Insurance Company represents that it has disclosed any and all current or potential conflicts of interest. A conflict of interest shall include transactions, activities or conduct that would affect the judgment, actions or work of the Insurance Company by placing the Insurance Company's own interests, or the interests of any party with whom the Insurance Company has a contractual arrangement, in conflict with those of the City. The City, in its sole discretion, will determine the existence of a conflict of interest and may terminate the Agreement if it determines a conflict exists, after it has given the Insurance Company written notice describing the conflict.

18. NOTICES: All notices required by the terms of the Agreement must be hand delivered, sent by overnight courier service, mailed by certified mail, return receipt requested, or mailed via United States mail, postage prepaid, if to Insurance Company at the address first above written, with a copy of any such notice to:

Denver Health and Hospital Authority
Attention: Office of the General Counsel
777 Bannock Street, Mail Code 1919
Denver, Colorado 80204

and if to the City at:

Executive Director
Office Human Resources
201 West Colfax Avenue, Dept. 412
Denver, Colorado 80202

With a copy of any such notice to:

Denver City Attorney's Office
1437 Bannock St., Room 353
Denver, Colorado 80202

Notices hand delivered or sent by overnight courier are effective upon delivery. Notices sent by certified mail are effective upon receipt. Notices sent by mail are effective upon deposit with the U.S. Postal Service. The parties may designate substitute addresses where or persons to whom notices are to be mailed or delivered. However, these substitutions will not become effective until actual receipt of written notification.

19. NO EMPLOYMENT OF ILLEGAL ALIENS TO PERFORM WORK UNDER THE AGREEMENT:

a. This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, and any amendments (the "Certification Ordinance").

b. The Insurance Company certifies that:

(1) At the time of its execution of this Agreement, it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement.

(2) It will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.

c. The Insurance Company also agrees and represents that:

(1) It shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(2) It shall not enter into a contract with a subconsultant or subcontractor that fails to certify to the Insurance Company that it shall not knowingly employ or contract with an illegal alien to perform work under the Agreement.

(3) It has confirmed the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement, through participation in either the E-Verify Program.

(4) It is prohibited from using either the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under the Agreement, and it is required to comply with any and all federal requirements related to use of

the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights.

(5) If it obtains actual knowledge that a subconsultant or subcontractor performing work under the Agreement knowingly employs or contracts with an illegal alien, it will notify such subconsultant or subcontractor and the City within three (3) days. The Insurance Company shall also terminate such subconsultant or subcontractor if within three (3) days after such notice the subconsultant or subcontractor does not stop employing or contracting with the illegal alien, unless during such three-day period the subconsultant or subcontractor provides information to establish that the subconsultant or subcontractor has not knowingly employed or contracted with an illegal alien.

(6) It will comply with any reasonable request made in the course of an investigation by the Colorado Department of Labor and Employment under authority of § 8-17.5-102(5), C.R.S., or the City Auditor, under authority of D.R.M.C. 20-90.3.

d. The Insurance Company is liable for any violations as provided in the Certification Ordinance. If Insurance Company violates any provision of this section or the Certification Ordinance, the City may terminate this Agreement for a breach of the Agreement. If the Agreement is so terminated, the Insurance Company shall be liable for actual and consequential damages to the City. Any such termination of a contract due to a violation of this section or the Certification Ordinance may also, at the discretion of the City, constitute grounds for disqualifying Insurance Company from submitting bids or proposals for future contracts with the City.

20. DISPUTE RESOLUTION PROCESS. Neither the Subscribing Group nor DHMP may initiate litigation to resolve any dispute without first attempting to resolve the dispute with the other party. The parties agree to meet in a good faith and collaborative effort to resolve the dispute, pursuant to the process specified in Article 4.10 of the Amended and Restated Operating Agreement between the City and County of Denver and Denver Health and Hospital Authority.

21. GOVERNING LAW AND VENUE; DAMAGES LIMITATION. The Agreement shall be governed and construed in accordance with laws of the State of Colorado. Any action or legal proceeding commenced or maintained by Subscribing Group or any employee or DHMP Member relating to or arising out of this Agreement or health plan must be exclusively

venued in a court of competent jurisdiction located in the City and County of Denver, Colorado. Subscribing Group, for itself and on behalf of its employees and their dependents who are covered individuals under this Agreement, agrees and consents to such venue and the subject matter and personal jurisdiction of such court located within Denver, Colorado. No court is empowered to award punitive damages or damages in excess of compensatory damages.

22. NO DISCRIMINATION IN EMPLOYMENT: In connection with the performance of work under the Agreement, the Insurance Company may not refuse to hire, discharge, promote or demote, or discriminate in matters of compensation against any person otherwise qualified, solely because of race, color, religion, national origin, gender, age, military status, sexual orientation, gender identity or gender expression, marital status, or physical or mental disability. The Insurance Company shall insert the foregoing provision in all subcontracts.

23. COMPLIANCE WITH ALL LAWS: Insurance Company shall perform or cause to be performed all services, both in this Agreement and pursuant to any insurance policies referenced in **Exhibit A**, in full compliance with all applicable laws, rules, regulations and codes of the United States, the State of Colorado; and with the applicable Charter, ordinances, rules, regulations and Executive Orders of the City and County of Denver.

24. LEGAL AUTHORITY: Insurance Company represents and warrants that it possesses the legal authority, pursuant to any proper, appropriate and official motion, resolution or action passed or taken, to enter into the Agreement. Each person signing and executing the Agreement on behalf of Insurance Company represents and warrants that he has been fully authorized by Insurance Company to execute the Agreement on behalf of Insurance Company and to validly and legally bind Insurance Company to all the terms, performances and provisions of the Agreement. The City shall have the right, in its sole discretion, to either temporarily suspend or permanently terminate the Agreement if there is a dispute as to the legal authority of either Insurance Company or the person signing the Agreement to enter into the Agreement.

25. NO CONSTRUCTION AGAINST DRAFTING PARTY: The parties and their respective counsel have had the opportunity to review the Agreement, and the Agreement will not be construed against any party merely because any provisions of the Agreement were prepared by a particular party.

26. ORDER OF PRECEDENCE: In the event of any conflicts between the language of the Agreement and the exhibits, the language of the Agreement controls.

27. SURVIVAL OF CERTAIN PROVISIONS: The terms of the Agreement and any exhibits and attachments that by reasonable implication contemplate continued performance, rights, or compliance beyond expiration or termination of the Agreement survive the Agreement and will continue to be enforceable. Without limiting the generality of this provision, the Insurance Company's obligations to provide insurance and to indemnify the City will survive for a period equal to any and all relevant statutes of limitation, plus the time necessary to fully resolve any claims, matters, or actions begun within that period.

28. ADVERTISING AND PUBLIC DISCLOSURE: The Insurance Company shall not include any reference to the Agreement or to services performed pursuant to the Agreement in any of the Insurance Company's advertising or public relations materials without first obtaining the written approval of the Executive Director. Any oral presentation or written materials related to services performed under the Agreement will be limited to services that have been accepted by the City. The Insurance Company shall notify the Executive Director in advance of the date and time of any presentation. Nothing in this provision precludes the transmittal of any information to City officials.

29. CONFIDENTIAL INFORMATION:

a. City Information: Insurance Company acknowledges and accepts that, in performance of all work under the terms of this Agreement, Insurance Company may have access to Proprietary Data or confidential information that may be owned or controlled by the City, and that the disclosure of such Proprietary Data or information may be damaging to the City or third parties. Insurance Company agrees that all Proprietary Data, confidential information or any other data or information provided or otherwise disclosed by the City to Insurance Company shall be held in confidence and used only in the performance of its obligations under this Agreement. Insurance Company shall exercise the same standard of care to protect such Proprietary Data and information as a reasonably prudent Insurance Company would to protect its own proprietary or confidential data. "Proprietary Data" shall mean any materials or information which may be

designated or marked "Proprietary" or "Confidential", or which would not be documents subject to disclosure pursuant to the Colorado Open Records Act or City ordinance, and provided or made available to Insurance Company by the City. Such Proprietary Data may be in hardcopy, printed, digital or electronic format.

30. CITY EXECUTION OF AGREEMENT: The Agreement will not be effective or binding on the City until it has been fully executed by all required signatories of the City and County of Denver, and if required by Charter, approved by the City Council.

31. AGREEMENT AS COMPLETE INTEGRATION-AMENDMENTS: The Agreement is the complete integration of all understandings between the parties as to the subject matter of the Agreement. No prior, contemporaneous or subsequent addition, deletion, or other modification has any force or effect, unless embodied in the Agreement in writing. No oral representation by any officer or employee of the City at variance with the terms of the Agreement or any written amendment to the Agreement will have any force or effect or bind the City.

32. USE, POSSESSION OR SALE OF ALCOHOL OR DRUGS: Insurance Company shall cooperate and comply with the provisions of Executive Order 94 and its Attachment A concerning the use, possession or sale of alcohol or drugs.

33. ELECTRONIC SIGNATURES AND ELECTRONIC RECORDS: Insurance Company consents to the use of electronic signatures by the City. The Agreement, and any other documents requiring a signature under the Agreement, may be signed electronically by the City in the manner specified by the City. The parties agree not to deny the legal effect or enforceability of the Agreement solely because it is in electronic form or because an electronic record was used in its formation. The parties agree not to object to the admissibility of the Agreement in the form of an electronic record, or a paper copy of an electronic document, or a paper copy of a document bearing an electronic signature, on the ground that it is an electronic record or electronic signature or that it is not in its original form or is not an original.

34. GRANT OF LIMITED LICENSE TO USE LOGO

a. City hereby grants to Insurance Company, subject to the terms and conditions set forth herein, a non-exclusive, nontransferable limited license, to use the "Denver D" logo ("**Denver Logo**") during the Term of this Agreement.

b. Insurance Company shall fully coordinate all logo use under this Agreement with the Denver Marketing Office ((720) 913-1633, denvermarketingoffice@denvergov.org), or otherwise as directed by the City.

c. The use of the Denver Logo is limited to display on the website to be created by Insurance Company pursuant to this Agreement and for the purpose of identification only. Insurance Company shall display the Denver Logo in a read-only format and shall not be used or displayed on the website in any format from which it can be downloaded, copied or reproduced in any manner.

d. The license granted by the City is non-transferable and non-assignable to anyone other than those acting under the supervision and authority of Insurance Company.

e. Insurance Company shall be solely responsible for the entire cost and expense of Insurance Company's Use of the Denver Logo.

f. The Denver Logo may not be used as a feature or design element of any other logo or graphic.

g. Insurance Company shall use the Denver Logo in accordance with any and all logo usage guidelines in effect from time-to-time as provided by the City. Insurance Company shall use only accurate reproductions of the Denver Logo. The size, proportions, colors, elements, and other distinctive characteristics of the Denver Logo shall not be altered in any manner except as may be permitted herein or as permitted in writing by the City.

h. Insurance Company shall affix a trademark ("™") or registration ("®") indication next to the Denver Logo as directed by the Denver Marketing Office.

i. Insurance Company shall immediately cease all use of the Denver Logo upon expiration of the Term of this Agreement, as may have been extended from time to time by the parties, in a formal written extension of this agreement.

Exhibit List:
Exhibit A – Summary of Benefits and Coverage & Performance Guarantees

[REMAINDER OF THIS PAGE IS BLANK]

Contract Control Number: CSAHR-201952649-00
Contractor Name: Denver Health Medical Plan, Inc.

IN WITNESS WHEREOF, the parties have set their hands and affixed their seals at Denver, Colorado as of:

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: _____

_____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: _____

REGISTERED AND COUNTERSIGNED:

By: _____

By: _____

Contract Control Number: CSAHR-201952649-00
Contractor Name: Denver Health Medical Plan, Inc.

By: _____

Name: Greg McCarthy
(please print)

Title: CEO
(please print)

EXHIBIT A
To 2020 Agreement with
DENVER HEALTH MEDICAL PLAN, INC.

SUMMARIES OF BENEFITS AND COVERAGE ("SBC")

SBC - HIGH DEDUCITBLE HEALTH PLAN

- **A-1: City & County of Denver Employees/Denver Employees Retirement Plan**
- **A-2: Denver Police Protection Association**

SBC - DHMO PLAN

- **A-3: City & County of Denver Employees/Denver Employees Retirement Plan**
- **A-4: Denver Police Protection Association**
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EXHIBIT A-1
To 2020 Agreement with
DENVER HEALTH MEDICAL PLAN, INC.

SUMMARIES OF BENEFITS AND COVERAGE ("SBC")

SBC - HIGH DEDUCITBLE HEALTH PLAN
City & County of Denver Employees/Denver Employees Retirement Plan

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?	$1,450 individual/$2,900 family for Denver Health Network. $2,500 individual/4,000 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. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
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 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?	$2,900 individual/$5,800 family for Denver Health Network. $5,000 individual/$8,000 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 members' expenses will count towards the overall family out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 a provider network. You will pay the least if you use a provider in the Denver Health network. You pay more if you use a provider in the Cofinity network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get 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?	No.	You can see the specialist you choose without a referral.

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)	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	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Specialist visit	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Preventive care/screening/ immunization	0% coinsurance	0% coinsurance	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required for PET scans and MRI.
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 $8 copay (discount); $10 copay (generic); $15 copay (non-preferred generic) Mail Order 90-day supply: DH Pharmacy $16 copay (discount); $20 copay (generic); $30 copay (non-preferred generic)	30-day supply: National Network Pharmacy $16 copay (discount); $20 copay (generic); $30 copay (non-preferred generic) Mail Order 90-day supply: National Network Pharmacy $32 copay (discount); $40 copay (generic); $60 copay (non-preferred generic)	Not covered	You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Deductible applies You may need to obtain certain

	Preferred brand drugs (Tier 3)	30-day supply: DH Pharmacy $30 copay; Mail Order 90-day supply: DH Pharmacy $60 copay	30-day supply: National Network Pharmacy $60 copay Mail Order 90-day supply: National Network Pharmacy $120 copay	Not covered	prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. You may be required to use a lower-cost drug(s). 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 $35 copay; Mail Order 90-day supply: DH Pharmacy $70 Copay	30-day supply: National Network Pharmacy $70 copay Mail Order 90-day supply: National Network Pharmacy $140 copay	Not covered	
	Specialty drugs (Tier 5)	30-day supply: DH Pharmacy $40 copay; Mail Order 90-day supply: N/A	30-day supply: National Network Pharmacy $80 copay. Mail Order 90-day supply: N/A	Not covered	Deductible applies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Waived if admitted.
	Emergency medical transportation	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	---------none----------
	Urgent care	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	---------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 10% coinsurance*	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
		Denver Health Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	---------none----------
	Inpatient services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If you are pregnant	Office visits	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	Preventive visits are $0
	Childbirth/delivery professional services	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Childbirth/delivery facility services	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
If you need help recovering or have other special health needs	Home health care	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required. Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy.
	Habilitation services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy.
	Skilled nursing care	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required. Coverage is limited to 100 days per calendar year.
	Durable medical equipment	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Hospice services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Excluded service.
	Children's glasses	Not covered	Not covered	Not covered	Excluded service.
	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.)		
• Bariatric surgery • Chiropractic care	• Hearing aids • Routine eye care	• 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:
(Español): Para obtener asistencia en Español, llame al 1-855-823-8872.
(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-823-8872.
(Chinese): (中文): 如果需要中文的帮助， **请拨打这个号码** 1-855-823-8872.
(Navajo)(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-823-8872.

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: $1450
- Specialist copayment: Deductible and 10% coinsurance
- Hospital (facility): Deductible and 10% coinsurance
- Other coinsurance: 0%

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 *(anesthesia)*

Total Example Cost	$12700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1450
Copayments	$0
Coinsurance	$1250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2760

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

- The plan's overall deductible: $1450
- Specialist copayment: Deductible and 10% coinsurance
- Hospital (facility): Deductible and 10% coinsurance
- Other coinsurance: 0%

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

Total Example Cost	$7400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1450
Copayments	$700
Coinsurance	$293
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2498

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

- The plan's overall deductible: $1450
- Specialist copayment: Deductible and coinsurance
- Hospital (facility): Deductible and 10% coinsurance
- Other coinsurance: 0%

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	$1900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1450
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1643

The plan would be responsible for the other costs of these EXAMPLE covered services.

EXHIBIT A-2
To 2020 Agreement with
DENVER HEALTH MEDICAL PLAN, INC.

SUMMARIES OF BENEFITS AND COVERAGE ("SBC")

SBC - HIGH DEDUCITBLE HEALTH PLAN
Denver Police Protection Association

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?	$1,450 individual/$2,900 family for Denver Health Network. $2,500 individual/$4,000 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. If you have other family members on the plan, the overall family deductible must be met before the plan begins to pay.
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 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?	$2,900 individual/$5,800 family for Denver Health Network. $5,000 individual/$8,000 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 members' expenses will count towards the overall family out-of-pocket limit.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 a provider network. You will pay the least if you use a provider in the Denver Health network. You pay more if you use a provider in the Cofinity network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get 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?	No.	You can see the specialist you choose without a referral.

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)	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	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Specialist visit	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Preventive care/screening/ immunization	0% coinsurance	0% coinsurance	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required for PET scans and MRI.
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 $8 copay (discount); $10 copay (generic); $15 copay (non-preferred generic) Mail Order 90-day supply: DH Pharmacy $16 copay (discount); $20 copay (generic); $30 copay (non-preferred generic)	30-day supply: National Network Pharmacy $16 copay (discount); $20 copay (generic); $30 copay (non-preferred generic) Mail Order 90-day supply: National Network Pharmacy $32 copay (discount); $40 copay (generic); $60 copay (non-preferred generic)	Not covered	You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Deductible applies You may need to obtain certain

	Preferred brand drugs (Tier 3)	30-day supply: DH Pharmacy $30 copay; Mail Order 90-day supply: DH Pharmacy $60 copay	30-day supply: National Network Pharmacy $60 copay Mail Order 90-day supply: National Network Pharmacy $120 copay	Not covered	prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. You may be required to use a lower-cost drug(s). 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 $35 copay; Mail Order 90-day supply: DH Pharmacy $70 Copay	30-day supply: National Network Pharmacy $70 copay Mail Order 90-day supply: National Network Pharmacy $140 copay	Not covered	
	Specialty drugs (Tier 5)	30-day supply: DH Pharmacy $40 copay; Mail Order 90-day supply: N/A	30-day supply: National Network Pharmacy $80 copay. Mail Order 90-day supply: N/A	Not covered	Deductible applies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Waived if admitted.
	Emergency medical transportation	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	---------none----------
	Urgent care	Deductible and 10% coinsurance	Deductible and 10% coinsurance	Deductible and 10% coinsurance	---------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 10% coinsurance*	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
		Denver Health Network Provider (You will pay the least)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	---------none----------
	Inpatient services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If you are pregnant	Office visits	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	Preventive visits are $0
	Childbirth/delivery professional services	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
	Childbirth/delivery facility services	Deductible and 10% coinsurance	Deductible and 20% coinsurance	Not covered	---------none----------
If you need help recovering or have other special health needs	Home health care	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required. Coverage is limited to 100 visits per calendar year.
	Rehabilitation services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy.
	Habilitation services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	Coverage is limited to 20 visits per calendar year per type of therapy.
	Skilled nursing care	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required. Coverage is limited to 100 days per calendar year.
	Durable medical equipment	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
	Hospice services	Deductible and 10% coinsurance*	Deductible and 20% coinsurance*	Not covered	*Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Excluded service.
	Children's glasses	Not covered	Not covered	Not covered	Excluded service.
	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.)		
• Bariatric surgery • Chiropractic care	• Hearing aids • Routine eye care	• 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:
(Español): Para obtener asistencia en Español, llame al 1-855-823-8872.
(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-823-8872.
(Chinese): (中文): 如果需要中文的帮助， **请拨打这个号码** 1-855-823-8872.
(Navajo)(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-823-8872.

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: $1450
- Specialist copayment: Deductible and 10% coinsurance
- Hospital (facility): Deductible and 10% coinsurance
- Other coinsurance: 0%

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 *(anesthesia)*

Total Example Cost	$12700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1450
Copayments	$0
Coinsurance	$1250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2760

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

- The plan's overall deductible: $1450
- Specialist copayment: Deductible and 10% coinsurance
- Hospital (facility): Deductible and 10% coinsurance
- Other coinsurance: 0%

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

Total Example Cost	$7400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1450
Copayments	$700
Coinsurance	$293
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2498

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

- The plan's overall deductible: $1450
- Specialist copayment: Deductible and coinsurance
- Hospital (facility): Deductible and 10% coinsurance
- Other coinsurance: 0%

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	$1900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1450
Copayments	$0
Coinsurance	$193
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1643

The plan would be responsible for the other costs of these EXAMPLE covered services.

EXHIBIT A-3
To 2020 Agreement with
DENVER HEALTH MEDICAL PLAN, INC.

SUMMARIES OF BENEFITS AND COVERAGE ("SBC")

SBC - DHMO PLAN
City & County of Denver Employees/Denver Employees Retirement Plan

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?	$500 individual/$1,500 family for Denver Health Network. $750 individual/$1,750 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. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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. 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $150 per occurrence for delivery and inpatient hospitalization or outpatient/ambulatory surgery.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers $3,000 individual/$6,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 a provider network. You will pay the least if you use a provider in the Denver Health Network. You pay more if you use a provider in the Cofinity Network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might 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?	No.	You can see the specialist you choose without a referral.

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)	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 per visit	$30 copay per visit	Not covered	---------none----------
	Specialist visit	$50 copay per visit	$50 copay per visit	Not covered	---------none----------
	Preventive care/screening/ immunization	0% coinsurance	0% coinsurance	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Deductible and 20% coinsurance	Deductible and 30% coinsurance	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	$150 copay per visit*	$200 copay per visit*	Not covered	*Pre-authorization required for PET scans and MRI.
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 $10 copay (discount); $12 copay (generic); $35 copay (non-preferred generic) Mail Order 90-day supply: DH Pharmacy $20 copay (discount); $24 copay (generic); $70 copay (non-preferred generic)	30-day supply: National Network Pharmacy $20 copay (discount); $24 copay (generic); $70 copay (non-preferred generic) Mail Order 90-day supply: National Network Pharmacy $40 copay (discount); $48 copay (generic); $140 copay (non-preferred generic)	Not covered	You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). You may need to obtain certain prescription drugs from a pharmacy designated by us.
	Preferred brand drugs	30-day supply: DH	30-day supply:	Not covered	

	(Tier 3)	Pharmacy $45 copay; **Mail Order 90-day supply:** DH Pharmacy $90 copay	National Network Pharmacy $90 copay. **Mail Order 90-day supply:** National Network Pharmacy $180 copay		Certain drugs may have a preauthorization requirement or result in a higher cost. Please see our website for information on drugs covered. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement, or result in a higher cost. Please see our website for information on drugs covered. You may be required to use a lower-cost drug(s). 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 $55 copay; **Mail Order 90-day supply:** DH Pharmacy $110 copay	**30-day supply:** National Network Pharmacy $110 copay. **Mail Order 90-day supply:** National Network Pharmacy $220 copay	Not covered	
	Specialty drugs (Tier 5)	**30-day supply**: DH Pharmacy $65 copay; **Mail Order 90-day supply:** DH Pharmacy N/A	**30-day supply**: National Network Pharmacy $130 copay. **Mail Order 90-day supply:** National Network Pharmacy N/A	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply*	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	$300 copay (deductible and coinsurance do not apply)	$300 copay (deductible and coinsurance do not apply)	$300 copay (deductible and coinsurance do not apply)	Waived if admitted.

	Emergency medical transportation	Deductible and 20% coinsurance	Deductible and 20% coinsurance	Deductible and 20% coinsurance	---------none----------
	Urgent care	$75 copay (deductible and coinsurance do not apply)	$75 copay (deductible and coinsurance do not apply)	$75 copay (deductible and coinsurance do not apply)	---------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after per occurrence deductible of $150 and annual deductible have been met*	30% coinsurance after per occurrence deductible of $150 and annual deductible have been met*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit	$50 copay per visit	Not covered	
	Inpatient services	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply	Not covered	---------none----------
If you are pregnant	Office visits	Deductible and 20% coinsurance	Deductible and 30% coinsurance	Not covered	Preventive visits are $0
	Childbirth/delivery professional services	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply	Not covered	---------none----------
	Childbirth/delivery facility services	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply	Not covered	---------none----------

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)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required. Coverage limited to 60 visits annually.
	Rehabilitation services	$25 copay per visit	$35 copay per visit	Not covered	Coverage is limited to 20 visits annually per type of therapy.
	Habilitation services	$25 copay per visit	$35 copay per visit	Not covered	Coverage is limited to 20 visits annually per type of therapy.
	Skilled nursing care	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required. Coverage limited to 100 days annually.
	Durable medical equipment	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
	Hospice services	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit	$35 copay per visit	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	Not covered	Not covered	Not covered	Excluded service.
	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 of the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care
- 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:
(Español): Para obtener asistencia en Español, llame al 1-855-823-8872.
(Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-823-8872.
(Chinese): (中文): 如果需要中文的帮助， **请拨打这个号码** 1-855-823-8872.
(Navajo)(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-823-8872.

———————————*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: $500
- Specialist copayment: $50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other coinsurance: 0%

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 *(anesthesia)*

Total Example Cost	$12700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$2480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3060

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

- The plan's overall deductible: $500
- Specialist copayment: $50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other coinsurance: 0%

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

Total Example Cost	$7400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1257
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2185

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

- The plan's overall deductible: $500
- Specialist copayment: $50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other coinsurance: 0%

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	$1900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$250
Coinsurance	$283
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1033

The plan would be responsible for the other costs of these EXAMPLE covered services.

EXHIBIT A-4
To 2020 Agreement with
DENVER HEALTH MEDICAL PLAN, INC.

SUMMARIES OF BENEFITS AND COVERAGE ("SBC")

SBC - DHMO PLAN
Denver Police Protection Association

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?	$500 individual/$1,500 family for Denver Health Network. $750 individual/$1,750 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. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
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. 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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $150 per occurrence for delivery and inpatient hospitalization or outpatient/ambulatory surgery.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For in-network providers $3,000 individual/$6,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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 a provider network. You will pay the least if you use a provider in the Denver Health Network. You pay more if you use a provider in the Cofinity Network. You will pay the most if you use an out-of-network provider and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might 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?	No.	You can see the specialist you choose without a referral.

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)	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 per visit	$30 copay per visit	Not covered	---------none----------
	Specialist visit	$50 copay per visit	$50 copay per visit	Not covered	---------none----------
	Preventive care/screening/ immunization	0% coinsurance	0% coinsurance	Not covered	---------none----------
If you have a test	Diagnostic test (x-ray, blood work)	Deductible and 20% coinsurance	Deductible and 30% coinsurance	Not covered	---------none----------
	Imaging (CT/PET scans, MRIs)	$150 copay per visit*	$200 copay per visit*	Not covered	*Pre-authorization required for PET scans and MRI.
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 $10 copay (discount); $12 copay (generic); $35 copay (non-preferred generic) Mail Order 90-day supply: DH Pharmacy $20 copay (discount); $24 copay (generic); $70 copay (non-preferred generic)	30-day supply: National Network Pharmacy $20 copay (discount); $24 copay (generic); $70 copay (non-preferred generic) Mail Order 90-day supply: National Network Pharmacy $40 copay (discount); $48 copay (generic); $140 copay (non-preferred generic)	Not covered	You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement or may result in a higher cost. Please see our website for information on drugs covered at retail or by mail order pharmacies. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). You may need to obtain certain prescription drugs from a pharmacy designated by us.
	Preferred brand drugs	30-day supply: DH	30-day supply:	Not covered	

	(Tier 3)	Pharmacy $45 copay; **Mail Order 90-day supply:** DH Pharmacy $90 copay	National Network Pharmacy $90 copay. **Mail Order 90-day supply:** National Network Pharmacy $180 copay		Certain drugs may have a preauthorization requirement or result in a higher cost. Please see our website for information on drugs covered. You may be required to use a lower-cost drug(s). Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). You may need to obtain certain prescription drugs from a pharmacy designated by DHMP. Certain drugs may have a preauthorization requirement, or result in a higher cost. Please see our website for information on drugs covered. You may be required to use a lower-cost drug(s). 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 $55 copay; **Mail Order 90-day supply:** DH Pharmacy $110 copay	**30-day supply:** National Network Pharmacy $110 copay. **Mail Order 90-day supply:** National Network Pharmacy $220 copay	Not covered	
	Specialty drugs (Tier 5)	**30-day supply**: DH Pharmacy $65 copay; **Mail Order 90-day supply:** DH Pharmacy N/A	**30-day supply**: National Network Pharmacy $130 copay. **Mail Order 90-day supply:** National Network Pharmacy N/A	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply*	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
If you need immediate medical attention	Emergency room care	$300 copay (deductible and coinsurance do not apply)	$300 copay (deductible and coinsurance do not apply)	$300 copay (deductible and coinsurance do not apply)	Waived if admitted.

	Emergency medical transportation	Deductible and 20% coinsurance	Deductible and 20% coinsurance	Deductible and 20% coinsurance	---------none----------
	Urgent care	$75 copay (deductible and coinsurance do not apply)	$75 copay (deductible and coinsurance do not apply)	$75 copay (deductible and coinsurance do not apply)	---------none----------
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after per occurrence deductible of $150 and annual deductible have been met*	30% coinsurance after per occurrence deductible of $150 and annual deductible have been met*	Not covered	*Pre-authorization required.
	Physician/surgeon fees	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay per visit	$50 copay per visit	Not covered	
	Inpatient services	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply	Not covered	---------none----------
If you are pregnant	Office visits	Deductible and 20% coinsurance	Deductible and 30% coinsurance	Not covered	Preventive visits are $0
	Childbirth/delivery professional services	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply	Not covered	---------none----------
	Childbirth/delivery facility services	Deductible of $150 per occurrence and 20% coinsurance after annual deductible apply	Deductible of $150 per occurrence and 30% coinsurance after annual deductible apply	Not covered	---------none----------

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)	Cofinity Network Provider	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required. Coverage limited to 60 visits annually.
	Rehabilitation services	$25 copay per visit	$35 copay per visit	Not covered	Coverage is limited to 20 visits annually per type of therapy.
	Habilitation services	$25 copay per visit	$35 copay per visit	Not covered	Coverage is limited to 20 visits annually per type of therapy.
	Skilled nursing care	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required. Coverage limited to 100 days annually.
	Durable medical equipment	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
	Hospice services	Deductible and 20% coinsurance*	Deductible and 30% coinsurance*	Not covered	*Pre-authorization required.
If your child needs dental or eye care	Children's eye exam	$25 copay per visit	$35 copay per visit	Not covered	Coverage is limited to one exam every 24 months.
	Children's glasses	Not covered	Not covered	Not covered	Excluded service.
	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 of the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Routine eye care
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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.

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(Navajo)(Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-823-8872.

———————————*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: $500
- Specialist copayment: $50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other coinsurance: 0%

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 *(anesthesia)*

Total Example Cost	$12700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$20
Coinsurance	$2480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3060

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

- The plan's overall deductible: $500
- Specialist copayment: $50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other coinsurance: 0%

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

Total Example Cost	$7400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1257
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2185

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

- The plan's overall deductible: $500
- Specialist copayment: $50 per visit
- Hospital (facility): Deductible and 20% coinsurance
- Other coinsurance: 0%

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	$1900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$250
Coinsurance	$283
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1033

The plan would be responsible for the other costs of these EXAMPLE covered services.