

SECOND AMENDMENT

THIS SECOND AMENDMENT (“Amendment”) is entered into by and between the **CITY AND COUNTY OF DENVER (“City”)** and **KAISER FOUNDATION HEALTH PLAN OF COLORADO**, a Colorado non-profit health plan whose address is 2500 S. Havana Street, Aurora, Colorado 80014 (the “Health Plan” or “Contractor”), jointly (“the Parties”).

RECITALS

WHEREAS, the Parties previously entered into an agreement identified with contract number CSAHR 202263753-00 dated June 05, 2024 (“**Agreement**”) and amended it in writing pursuant to contract number CSAHR 202263753-01, dated March 05, 2025.

WHEREAS, the Parties intend to amend the Agreement to: update Exhibit A-2 with 2026 policy information, update Exhibit A-3 with 2026 performance metrics, extend the term of the agreement; and, to increase the maximum contract amount as described herein.

NOW, THEREFORE, in consideration of the premises and the mutual covenants and agreements contained in the Agreement and hereinafter set forth, the Parties agree as follows:

1. Exhibit A-2 shall be updated and replaced with the 2026 policy information attached hereto and marked “**Exhibit A-2**”.

2. Exhibit A-3 shall be updated and replaced with the 2026 performance metrics attached hereto and marked “**Exhibit A-3**”.

3. Modification of Term. The first sentence of Paragraph 4 of the Agreement (entitled “**Term**”) is hereby amended to read as follows:

“4. **TERM**: This Agreement is effective beginning on **January 1, 2023**, and shall expire at 11:59 p.m. on **December 31, 2026** (the “**Term**”).”

THIS SPACE INTENTIONALLY LEFT BLANK

4. Modification of Compensation and Payment. Paragraph 5(d)(1) of the Agreement (entitled “Maximum Contract Amount”) is hereby amended and restated to read as follows:

“5. **COMPENSATION AND PAYMENT:**

(d)(1) **Maximum Contract Amount:** Notwithstanding any other provision of the Agreement, the City’s maximum payment obligation will not exceed **THREE HUNDRED EIGHTY-ONE MILLION DOLLARS AND NO CENTS (\$381,000,000.00)** (the “Maximum Contract Amount”). The Maximum Contract Amount is comprised of: \$97,000,000.00 for 1/1/2023-12/31/2023 covering the City and County of Denver #75, Denver Police Department #68 and Denver Fire Department #74; \$91,000,000.00 for 1/1/2024-12/31/2024, covering the City and County of Denver #75 and Denver Police Department #68; \$93,000,000.00 for 1/1/2025-12/31/2025, covering the City and County of Denver #75 and Denver Police Department #68, and \$100,000,000 for 2026 covering the City and County of Denver #75 and Denver Police Department #68. The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Contractor beyond that specifically described in Exhibit A. Any services performed beyond those in Exhibit A are performed at Contractor’s risk and without authorization under the Agreement.

4. This Amendment may be executed in counterparts, each of which shall be deemed to be an original, and all of which, taken together, shall constitute one and the same instrument.

5. Except as herein amended, the Agreement is affirmed and ratified in each and every particular.

[SIGNATURE PAGES TO FOLLOW]

Contract Control Number:
Contractor Name:

CSAHR-202263753-02
Kaiser Foundation Health Plan of Colorado

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:

REGISTERED AND COUNTERSIGNED:

Attorney for the City and County of Denver

By:

By:

By:

Contract Control Number:
Contractor Name:

CSAHR-202263753-02
Kaiser Foundation Health Plan of Colorado

Signed by:
Sarah Allen
By: _____
A14CEEB00724440...

Name: Sarah Allen
(please print)

Title: MSBD, VP
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A-2
TO
AGREEMENT BETWEEN
CITY & COUNTY OF DENVER and
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-2 Summary of Benefits and Coverage (SBC)

1. SBC - City and County of Denver DHMO 500 20%
Covered Services Coverage Period: 01/01/2026-12/31/2026
2. SBC - Denver Police Department DHMO 500 20%
Covered Services Coverage Period: 01/01/2026-12/31/2026
3. SBC - City and County of Denver HDHP 1700 AGG 20%.
Covered Services Coverage Period: 01/01/2026-12/31/2026
4. SBC - Denver Police Department HDHP 1700 AGG 20%.
Covered Services Coverage Period: 01/01/2026-12/31/2026
5. EOC - City and County of Denver Insert 2026
6. EOC - Denver Police Department Insert Non-Medicare 2026
7. EOC - Denver Police Department Insert Medicare 2026

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026-12/31/2026

 **KAISER PERMANENTE®** : City and County of Denver DHMO 500 20%

Coverage for: Individual / Family | Plan Type: HMO

 **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. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-855-249-5005 (TTY:711). 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.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 Individual / \$1,000 Family	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 and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$4,500 Individual / \$9,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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 , health care this plan doesn't cover, and services indicated in chart starting on page 2.	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.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's 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.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist ?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Virtual Care Services: No charge, deductible does not apply.
	Specialist visit	\$75 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Virtual Care Services: No charge, deductible does not apply
	Preventive care/ screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: No charge, deductible does not apply. Lab tests: \$25 / visit, deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRI's)	\$250 / test, deductible does not apply	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.kp.org/formulary</p>	Generic drugs	\$10 retail and \$20 mail order / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Prescription refills of ongoing maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to formulary guidelines. Formulary preventive and contraceptive drugs in all tiers are no charge, deductible does not apply.
	Preferred brand drugs	\$35 retail and \$70 mail order / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$60 retail and \$120 mail order / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	\$100 retail / prescription , deductible does not apply	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgical center: \$500 / surgery, deductible does not apply. Outpatient hospital: 20% coinsurance .	Not covered	None
	Physician/surgeon fees	Ambulatory surgical center: No charge, deductible does not apply. Outpatient hospital: 20% coinsurance .	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Imaging (CT/PET scans, MRI) copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance , deductible does not apply	20% coinsurance , deductible does not apply	None
	Urgent care	\$0 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Non-plan providers : only covered if you are out of the service area: No charge, deductible does not apply. 20% coinsurance for other covered services received during a visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fee	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, deductible does not apply	Not covered	Annual Wellness Visit and Virtual Care Services: No charge, deductible does not apply.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Less than 8 hours / day and 28 hours / week.
	Rehabilitation services	Outpatient services: 20% coinsurance . Inpatient services: 20% coinsurance .	Not covered	Outpatient: 60 visit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge, deductible does not apply. Inpatient: Limited to 60 days / condition / year.
	Habilitation services	Outpatient services: 20% coinsurance	Not covered	60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge, deductible does not apply.
	Skilled nursing care	20% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines.
	Hospice service	No charge, deductible does not apply	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$0 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Limited to members up to the end of the year in which the member turns 19.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 .)		
<ul style="list-style-type: none"> ● Acupuncture ● Children's dental check-up ● Children's glasses 	<ul style="list-style-type: none"> ● Cosmetic surgery ● Dental care (Adult) ● Long-term care 	<ul style="list-style-type: none"> ● Non-emergency care when traveling outside the U.S. ● Routine foot care ● Weight loss programs

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

- Bariatric surgery
- Chiropractic care (20 visit limit/year)
- Hearing aids (Adult: \$1,000 limit/ear, every 36 months; Up to age 18: 1 aid / ear / 60 months)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

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 shown in the chart below. 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 on how 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-855-249-5005 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Colorado Division of Insurance	303-894-7490 (instate, toll-free: 800-930-3745) or insurance@dora.state.co.us

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5005 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-855-249-5005 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5005 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-249-5005 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5005 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-855-249-5005 (TTY: 711)

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](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

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](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$700

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	City and County of Denver DHMO 500 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available only in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld KP Select Plan: El Paso and Teller

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.

<p>8. What cancer screenings are covered?</p>	<p>Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))</p>
--	--

USING THE PLAN

	<p>IN-NETWORK</p>	<p>OUT-OF-NETWORK</p>
<p>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	<p>No</p>	<p>Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility.</p>
<p>10. Does the plan have a binding arbitration clause?</p>	<p>No</p>	

Questions: Call **1-855-249-5005** (TTY **711**) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-855-249-5005** (TTY **711**).

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY **711**).

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al **711**).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no-cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, age, disability, sex, (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, (TTY **1-800-537-7697**). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This notice is available at <https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700 (TTY 711)**.

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-632-9700 (TTY 711)**.

Bàsòò Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoṅ ni soṅ, niṅ ma kénṅen yé, mbi èyem. Wò nàṅ **1-800-632-9700 (TTY 711)**

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700 (TTY 711)**。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-632-9700** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700 (TTY 711)**.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY 711).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesiri ekwesị, n'efu, di nye gi. Kpọ **1-800-632-9700 (TTY 711)**.

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-632-9700** までお電話ください (TTY : **711**)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700**로 전화해 주세요 (TTY **711**).

Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700 (TTY 711)**.

नेपाली (Nepali) ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन **1-800-632-9700 (TTY: 711)**.

Afaan Oromoo (Oromo) XIYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700 (TTY 711)**.

Español (Spanish) ATENCION: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Yorùbá, àwọn isẹ̀ irànlọ̀wọ̀ èdè tó fi kún àwọn ohun èlò irànlọ̀wọ̀ tó yẹ àti àwọn isẹ̀ láísí idíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).

This page is intentionally left blank.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026-12/31/2026

 **KAISER PERMANENTE®** : **Denver Police Department DHMO 500 20%**

Coverage for: Individual / Family | Plan Type: HMO

 **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. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-855-249-5005 (TTY:711). 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.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$500 Individual / \$1,000 Family	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 and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$4,500 Individual / \$9,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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 , health care this plan doesn't cover, and services indicated in chart starting on page 2.	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.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's 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.

Important Questions	Answers	Why this Matters:
Do you need a referral to see a specialist ?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$0 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Virtual Care Services: No charge, deductible does not apply
	Specialist visit	\$75 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Virtual Care Services: No charge, deductible does not apply
	Preventive care/ screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Xray: No charge, deductible does not apply. Lab tests: \$25 / visit, deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRI's)	\$250 / test, deductible does not apply	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.kp.org/formulary</p>	Generic drugs	\$10 retail and \$20 mail order / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Prescription refills of ongoing maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to formulary guidelines. Formulary preventive and contraceptive drugs in all tiers are no charge, deductible does not apply.
	Preferred brand drugs	\$35 retail and \$70 mail order / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$60 retail and \$120 mail order / prescription , deductible does not apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	\$100 retail / prescription , deductible does not apply	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgical center: \$500 / surgery, deductible does not apply. Outpatient hospital: 20% coinsurance .	Not covered	None
	Physician/surgeon fees	Ambulatory surgical center: No charge, deductible does not apply. Outpatient hospital: 20% coinsurance .	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Imaging (CT/PET scans, MRI) copayment waived if admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance , deductible does not apply	20% coinsurance , deductible does not apply	None
	Urgent care	\$0 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Non-plan providers : only covered if you are out of the service area: No charge, deductible does not apply. 20% coinsurance for other covered services received during a visit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fee	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge, deductible does not apply	Not covered	Annual Wellness Visit and Virtual Care Services: No charge, deductible does not apply.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Less than 8 hours / day and 28 hours / week.
	Rehabilitation services	Outpatient services: 20% coinsurance . Inpatient services: 20% coinsurance .	Not covered	Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge, deductible does not apply. Inpatient: Limited to 60 days / condition / year.
	Habilitation services	Outpatient services: 20% coinsurance	Not covered	Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge, deductible does not apply.
	Skilled nursing care	20% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines.
	Hospice service	No charge, deductible does not apply	Not covered	None
If your child needs dental or eye care	Children's eye exam	\$0 / visit, deductible does not apply. 20% coinsurance for other covered services received during a visit.	Not covered	Limited to members up to the end of the year in which the member turns 19.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 .)		
<ul style="list-style-type: none"> ● Acupuncture ● Children's dental check-up ● Children's glasses 	<ul style="list-style-type: none"> ● Cosmetic surgery ● Dental care (Adult) ● Long-term care 	<ul style="list-style-type: none"> ● Non-emergency care when traveling outside the U.S. ● Routine foot care ● Weight loss programs

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

- Bariatric surgery
- Chiropractic care (20 visit limit/year)
- Hearing aids (Adult: \$1,000 limit/ear, every 36 months; Up to age 18: 1 aid / ear / 60 months)
- Infertility treatment
- Private-duty nursing
- Routine eye care (Adult)

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 shown in the chart below. 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 on how 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-855-249-5005 (TTY: 711) or www.kp.org/memberservices
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Colorado Division of Insurance	303-894-7490 (instate, toll-free: 800-930-3745) or insurance@dora.state.co.us

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5005 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deitsch, ruf 1-855-249-5005 (TTY: 711) uff

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-249-5005 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-855-249-5005 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5005 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-855-249-5005 (TTY: 711)

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](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$2,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,860

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](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$700

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$75
- Hospital (facility) [coinsurance](#) 20%
- Other [copayment](#) \$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	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Police Department DHMO 500 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available only in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld KP Select Plan: El Paso and Teller

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.

<p>8. What cancer screenings are covered?</p>	<p>Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))</p>
--	--

USING THE PLAN

	<p>IN-NETWORK</p>	<p>OUT-OF-NETWORK</p>
<p>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	<p>No</p>	<p>Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility.</p>
<p>10. Does the plan have a binding arbitration clause?</p>	<p>No</p>	

Questions: Call **1-855-249-5005** (TTY **711**) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-855-249-5005** (TTY **711**).

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY **711**).

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al **711**).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no-cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, age, disability, sex, (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, (TTY **1-800-537-7697**). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This notice is available at <https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700 (TTY 711)**.

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-632-9700 (TTY 711)**.

Bàsòò Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsoṅ ni soṅ, niṅ ma kénṅen yé, mbi èyem. Wò nàṅ **1-800-632-9700 (TTY 711)**

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700 (TTY 711)**。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-632-9700** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700 (TTY 711)**.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenten mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY 711).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesiri ekwesị, n'efu, di nye gi. Kpọ **1-800-632-9700 (TTY 711)**.

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-632-9700** までお電話ください (TTY : **711**)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700**로 전화해 주세요 (TTY **711**).

Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700 (TTY 711)**.

नेपाली (Nepali) ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन **1-800-632-9700 (TTY: 711)**.

Afaan Oromoo (Oromo) XIYYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700 (TTY 711)**.

Español (Spanish) ATENCION: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá n sọ èdè Yorùbá, àwọn isẹ̀ ìrànlọ́wọ̀ èdè tó fi kún àwọn ohun èlò ìrànlọ́wọ̀ tó yẹ àti àwọn isẹ̀ láísí idíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).

This page is intentionally left blank.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026-12/31/2026

 **KAISER PERMANENTE®** : **City and County of Denver HDHP 1700 AGG 20%**

Coverage for: Individual / Family | Plan Type: HDHP

 **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. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-855-249-5005 (TTY:711). 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.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,700 Individual / \$3,400 Family	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 policy, 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 and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$3,300 Individual / \$6,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2.	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.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's 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.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	Virtual Care Services: No charge
	Specialist visit	20% coinsurance	Not covered	Virtual Care Services: No charge
	Preventive care/screening/immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRI's)	20% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.kp.org/formulary	Generic drugs	\$10 retail and \$20 mail order / prescription .	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Prescription refills of ongoing maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to formulary guidelines. Formulary preventive and contraceptive drugs in all tiers are no charge, deductible does not apply.
	Preferred brand drugs	\$35 retail and \$70 mail order / prescription .	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$60 retail and \$120 mail order / prescription .	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgical center: 10% coinsurance . Outpatient hospital: 20% coinsurance .	Not covered	None
	Physician/surgeon fees	Ambulatory surgical center: 10% coinsurance . Outpatient hospital: 20% coinsurance .	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Not covered	Non-Plan Providers covered when temporarily outside the service area: 20% coinsurance .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fee	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Annual Wellness Visit: No charge, deductible does not apply. Virtual Care Services: No charge.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Less than 8 hours / day and 28 hours / week.
	Rehabilitation services	Outpatient services: 20% coinsurance . Inpatient services: 20% coinsurance .	Not covered	Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge. Inpatient: Limited to 60 days / condition / year.
	Habilitation services	Outpatient services: 20% coinsurance	Not covered	60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge.
	Skilled nursing care	20% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines.
	Hospice service	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance	Not covered	Limited to members up to the end of the year in which the member turns 19.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 .)		
<ul style="list-style-type: none"> ● Acupuncture ● Children's dental check-up ● Children's glasses 	<ul style="list-style-type: none"> ● Cosmetic surgery ● Dental care (Adult) ● Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> ● Routine foot care ● Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> ● Bariatric surgery ● Chiropractic care (20 visit limit/year) ● Hearing aids (Adult: \$1,000 limit/ear, every 36 months; up to age 18: 1 aid / ear / 60 months) 	<ul style="list-style-type: none"> ● Infertility treatment ● Long-term care 	<ul style="list-style-type: none"> ● Private-duty nursing (Inpatient) ● Routine eye care (Adult)

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 shown in the chart below. 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 on how 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-855-249-5005 (TTY: 711) or www.kp.org/memberservices
Department of Labor’s Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Colorado Division of Insurance	303-894-7490 (instate, toll-free: 800-930-3745) or insurance@dora.state.co.us

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn’t meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5005 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-855-249-5005 (TTY: 711) uff

NAVAJO (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-855-249-5005 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala’au mai i le numera telefoni 1-855-249-5005 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5005 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-855-249-5005 (TTY: 711)

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](#) \$3,400
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:
[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$3,400
Copayments	\$10
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,270

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

- The [plan's](#) overall [deductible](#) \$1,700
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,100

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

- The [plan's](#) overall [deductible](#) \$1,700
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$10
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,910

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	City and County of Denver HDHP 1700 AGG 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available only in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld KP Select Plan: El Paso and Teller

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	AGGREGATE DEDUCTIBLE INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.
5. Out-of-Pocket Maximum	AGGREGATE OUT-OF-POCKET INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.

<p>8. What cancer screenings are covered?</p>	<p>Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))</p>
--	--

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
<p>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	<p>No</p>	<p>Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility.</p>
<p>10. Does the plan have a binding arbitration clause?</p>	<p>No</p>	

Questions: Call **1-855-249-5005** (TTY **711**) or visit us at www.kp.org.
 SPANISH (Español): Para obtener asistencia en Español, llame al **1-855-249-5005** (TTY **711**).

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY **711**).
 Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al **711**).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no-cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, age, disability, sex, (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, (TTY **1-800-537-7697**). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This notice is available at <https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700 (TTY 711)**.

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-632-9700 (TTY 711)**.

Bàsòò Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsonj ni sonj, niŋ ma kénŋen yé, mbi èyem. Wò nàŋ **1-800-632-9700 (TTY 711)**

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700 (TTY 711)**。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-632-9700** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700 (TTY 711)**.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistentz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY 711).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesiri ekwesị, n'efu, di nye gi. Kpọ **1-800-632-9700 (TTY 711)**.

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-632-9700** までお電話ください (TTY : **711**)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700**로 전화해 주세요 (TTY **711**).

Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700 (TTY 711)**.

नेपाली (Nepali) ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन **1-800-632-9700 (TTY: 711)**.

Afaan Oromoo (Oromo) XIYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700 (TTY 711)**.

Español (Spanish) ATENCION: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá n sọ èdè Yorùbá, àwọn isẹ̀ ìrànlowọ̀ èdè tó fi kún àwọn ohun èlò ìrànlowọ̀ tó yẹ àti àwọn isẹ̀ láísí idíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).

This page is intentionally left blank.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026-12/31/2026

 **KAISER PERMANENTE®** : **Denver Police Department HDHP 1700 AGG 20%**

Coverage for: Individual / Family | Plan Type: HDHP

 **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. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage see <https://kp.org/plandocuments> or call 1-855-249-5005 (TTY:711). 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.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$1,700 Individual / \$3,400 Family	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 policy, 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 and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$3,300 Individual / \$6,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums , health care this plan doesn't cover, and services indicated in chart starting on page 2.	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.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's 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.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists .	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 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 Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	Virtual Care Services: No charge
	Specialist visit	20% coinsurance	Not covered	Virtual Care Services: No charge
	Preventive care/screening/immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRI's)	20% coinsurance	Not covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.kp.org/formulary	Generic drugs	\$10 retail and \$20 mail order / prescription .	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Prescription refills of ongoing maintenance medications must be filled at a Kaiser Permanente Pharmacy. Subject to formulary guidelines. Formulary preventive and contraceptive drugs in all tiers are no charge, deductible does not apply.
	Preferred brand drugs	\$35 retail and \$70 mail order / prescription .	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines.
	Non-preferred drugs	\$60 retail and \$120 mail order / prescription .	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to formulary guidelines, when approved through the exception process.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Up to a 30-day supply (retail). Subject to formulary guidelines, when approved through the exception process.

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Ambulatory surgical center: 10% coinsurance . Outpatient hospital: 20% coinsurance .	Not covered	None
	Physician/surgeon fees	Ambulatory surgical center: 10% coinsurance . Outpatient hospital: 20% coinsurance .	Not covered	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	Not covered	Non-Plan Providers covered when temporarily outside the service area: 20% coinsurance .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fee	20% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	Not covered	Annual Wellness Visit: No charge, deductible does not apply. Virtual Care Services: No charge.
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	20% coinsurance	Not covered	Cost sharing does not apply for preventive services . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	20% coinsurance	Not covered	None
	Childbirth/delivery facility services	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay Plan Provider (You will pay the least)	What You Will Pay Non-Plan Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Less than 8 hours / day and 28 hours / week.
	Rehabilitation services	Outpatient services: 20% coinsurance . Inpatient services: 20% coinsurance .	Not covered	Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge. Inpatient: Limited to 60 days / condition / year.
	Habilitation services	Outpatient services: 20% coinsurance	Not covered	Outpatient: 60 visit limit / therapy / year (autism spectrum disorders are not subject to visit limit). Virtual Care Services: No charge.
	Skilled nursing care	20% coinsurance	Not covered	100-day limit / year.
	Durable medical equipment	20% coinsurance	Not covered	Subject to formulary guidelines.
	Hospice service	20% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance	Not covered	Limited to members up to the end of the year in which the member turns 19.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 .)		
<ul style="list-style-type: none"> ● Acupuncture ● Children's dental check-up ● Children's glasses 	<ul style="list-style-type: none"> ● Cosmetic surgery ● Dental care (Adult) ● Long-term care 	<ul style="list-style-type: none"> ● Non-emergency care when traveling outside the U.S. ● Routine foot care ● Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> ● Bariatric surgery ● Chiropractic care (20 visit limit/year) 	<ul style="list-style-type: none"> ● Hearing aids (\$1,000 limit/ear, every 36 months; Up to age 18: 1 aid / ear / 60 months) ● Infertility treatment 	<ul style="list-style-type: none"> ● Private-duty nursing (Inpatient) ● Routine eye care (Adult)

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 shown in the chart below. 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 on how 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 the agencies in the chart below.

Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:

Kaiser Permanente Member Services	1-855-249-5005 (TTY: 711) or www.kp.org/memberservices
Department of Labor’s Employee Benefits Security Administration	1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or www.cciio.cms.gov
Colorado Division of Insurance	303-894-7490 (instate, toll-free: 800-930-3745) or insurance@dora.state.co.us

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your [plan](#) doesn’t meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 (TTY: 711)

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 (TTY: 711)

TRADITIONAL CHINESE (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-249-5005 (TTY: 711)

PENNSYLVANIA DUTCH (Deutsch): Fer Hilf griege in Deutsch, ruf 1-855-249-5005 (TTY: 711) uff

NAVAJO (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-855-249-5005 (TTY: 711)

SAMOAN (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala’au mai i le numera telefoni 1-855-249-5005 (TTY: 711)

CAROLINIAN (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-855-249-5005 (TTY: 711)

CHAMORRO (Chamoru): Para un ma ayuda gi finu Chamoru, à'gang 1-855-249-5005 (TTY: 711)

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](#) \$3,400
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

This EXAMPLE event includes services like:
[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$3,400
Copayments	\$10
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,270

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

- The [plan's](#) overall [deductible](#) \$1,700
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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	\$5,600
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$2,100

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

- The [plan's](#) overall [deductible](#) \$1,700
- [Specialist coinsurance](#) 20%
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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

Total Example Cost	\$2,800
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles	\$1,700
Copayments	\$10
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,910

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Police Department HDHP 1700 AGG 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available only in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld KP Select Plan: El Paso and Teller

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	AGGREGATE DEDUCTIBLE INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid for any family member. The family deductible can be met by one or more individuals.
5. Out-of-Pocket Maximum	AGGREGATE OUT-OF-POCKET INDIVIDUAL – The amount that a single person without any family members on the plan will have to pay each year prior to claims being paid at 100%. FAMILY – The amount that a family with more than one individual on the plan will have to pay each year prior to claims being paid at 100% for any family member. The family out-of-pocket can be met by one or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.
7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.

<p>8. What cancer screenings are covered?</p>	<p>Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))</p>
--	--

USING THE PLAN

	<p>IN-NETWORK</p>	<p>OUT-OF-NETWORK</p>
<p>9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?</p>	<p>No</p>	<p>Yes, members may be responsible for any amounts over eligible Charges, except when Emergency Services are received in an Out-of-Plan Facility or from an Out-of-Plan Provider in a Plan Facility.</p>
<p>10. Does the plan have a binding arbitration clause?</p>	<p>No</p>	

Questions: Call **1-855-249-5005** (TTY **711**) or visit us at www.kp.org.

SPANISH (Español): Para obtener asistencia en Español, llame al **1-855-249-5005** (TTY **711**).

This document is available for free in Spanish. Please contact our Member Services number at **303-338-3800** or toll free **1-800-632-9700** (TTY **711**).

Este documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestro Servicio a los Miembros al **303-338-3800** or toll free **1-800-632-9700**. (Los usuarios de la línea TTY deben llamar al **711**).

If you are not satisfied with the resolution of your complaint or grievance, contact:

Colorado Division of Insurance
 Consumer Services, Life and Health Section
 1560 Broadway, Suite 850, Denver, CO 80202
 Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
 Email: dora_insurance@state.co.us

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal and state civil rights laws and does not discriminate, exclude people or treat them less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), ancestry, age, disability, sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed or marital status.

Kaiser Health Plan:

- Provides no-cost auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats, such as large print, audio, braille, and accessible electronic formats
- Provides no-cost language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call **1-800-632-9700** (TTY **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, age, disability, sex, (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, gender expression, and sex stereotypes), religion, creed, or marital status, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, (TTY **1-800-537-7697**). Complaint forms are available at hhs.gov/ocr/office/file/index.html.

This notice is available at <https://healthy.kaiserpermanente.org/colorado/language-assistance/nondiscrimination-notice>

HELP IN YOUR LANGUAGE

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-632-9700 (TTY 711)**.

አማርኛ (Amharic) ትኩረት: አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ **1-800-632-9700** ይደውሉ (TTY 711)።

العربية (Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة بالمجان. اتصل بالرقم **1-800-632-9700 (TTY 711)**.

Bàsòò Wùdù (Bassa) Mbi sog: nia maa Bàsàa, njàl mbom a ka maa njàng ndol ni mbom mi tsonj ni sonj, niŋ ma kénŋen yé, mbi èyem. Wò nàŋ **1-800-632-9700 (TTY 711)**

中文 (Chinese) 注意事項: 如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-632-9700 (TTY 711)**。

فارسی (Farsi) توجه: اگر به زبان فارسی صحبت می‌کنید، «تسهیلات زبانی»، از جمله کمک‌ها و خدمات پشتیبانی مناسب، به صورت رایگان در دسترس‌تان است با **1-800-632-9700** تماس بگیرید (TTY (تلفن متنی): **711**).

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-632-9700 (TTY 711)**.

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie **1-800-632-9700** an (TTY 711).

Igbo (Igbo) TINYE UCHE: Ọ bụrụ na ị na-asụ Igbo, Ọrụ enyemaka nke asụsụ gụnyere udi enyemaka na ọrụ kwesiri ekwesị, n'efu, di nye gi. Kpọ **1-800-632-9700 (TTY 711)**.

日本語 (Japanese) 注意: 日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。 **1-800-632-9700** までお電話ください (TTY : **711**)。

한국어 (Korean) 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. **1-800-632-9700**로 전화해 주세요 (TTY **711**).

Naabeehó (Navajo) Díí BAA AKÓ NÍNÍZIN: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', biniit'aa da beeso ndinish'aah t'aala'l bi'aa 'anashwo' doo biniit'aa, t'aadoo baahilinigoo bits'aadoo yeel, t'áá jiik'eh, éí ná hóló, koji' hódíílnih **1-800-632-9700 (TTY 711)**.

नेपाली (Nepali) ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहित भाषा सहायता सेवाहरू, निःशुल्क उपलब्ध छन्। फोन **1-800-632-9700 (TTY: 711)**.

Afaan Oromoo (Oromo) XIYEEFFANNOO: Yoo Afaan Oromo dubbattu ta'e, Tajaajila gargaarsa afaanii, gargaarsota dabalataa fi tajaajiloota barbaachisoo kaffaltii irraa bilisa ta'an, isiniif ni jira. **1-800-632-9700** irratti bilbilaa (TTY **711**)

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру **1-800-632-9700 (TTY 711)**.

Español (Spanish) ATENCION: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) ÀKÍYÈSÍ: Tí o bá ń sọ èdè Yorùbá, àwọn isẹ̀ irànlọ́wọ̀ èdè tó fi kún àwọn ohun èlò irànlọ́wọ̀ tó yẹ àti àwọn isẹ̀ láísí idíyelé wà fún ọ. Pe **1-800-632-9700** (TTY **711**).

This page is intentionally left blank.

CITY AND COUNTY OF DENVER
EVIDENCE OF COVERAGE AMENDMENT - 2026

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

- 1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.
- 2) "Eligible dependent" shall mean the primary insured's child or spouse
 - a) An eligible dependent may not also be a primary insured on the same insurance plan.
 - b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
 - c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
 - d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.
- 3) "Eligible employee" shall mean: career service employees as defined in section 9.1.1(e) of the charter, appointed charter officers as defined in section 9.2.1(B) of the charter, and elected charter officers as defined in section 9.2.1 (A) of the charter. The definition of eligible employee shall not include:
 - a) Part-time employees who are regularly scheduled to work less than twenty (20) hours per week;
 - b) Members of the classified service of the police and fire departments; and,
 - c) Persons occupying or employed in on-call (Eligible if employed for 12 months and averaging at least 30 hours per week in accordance with the Patient Protection and Affordable Care Act), temporary, seasonal, or contract positions, or positions in which the incumbent is paid according to the community rate schedule.
- 4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.
- 5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.
- 6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse or a spousal equivalent.
- 7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.
- 8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.
- 9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
 - a) A primary insured may not also be an eligible dependent on the same insurance.
- 10) "Spouse" shall mean an eligible employee's lawful spouse through marriage or common-law.
- 11) "Spousal equivalent" shall mean an adult with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section an affidavit of spousal equivalency, an affidavit of domestic partnership, or a civil union license.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

- c. Other dependent persons (but not including foster children) who meet all of the following requirements:
 - i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
 - ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18).

(Ord. No. 959-05, § 1, 12-19-05; Ord. No. 661-12, § 3, 12-26-12; Ord. No. 489-14, § 1, 9-8-14; Ord. No. 763-17, § 1, 8-7-17)

**DENVER POLICE DEPARTMENT
NON-MEDICARE EMPLOYEES**

EVIDENCE OF COVERAGE AMENDMENT - 2026

I. The following definitions are *in addition* to those detailed in this Evidence of Coverage (EOC).

- 1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.
- 2) "Eligible dependent" shall mean the primary insured's child or spouse
 - a) An eligible dependent may not also be a primary insured on the same insurance plan.
 - b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
 - c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
 - d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.
- 3) "Eligible employee" shall mean:
 - a) Members of the classified service of the police department.
- 4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.
- 5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.
- 6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse or a spousal equivalent.
- 7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.
- 8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.
- 9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
 - a) A primary insured may not also be an eligible dependent on the same insurance.
- 10) "Spouse" shall mean an eligible employee's lawful spouse, through marriage or common-law.
- 11) "Spousal equivalent" shall mean an adult with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency, an affidavit of domestic partnership, or a civil union license.

II. The following definition is removed from those detailed in this Evidence of Coverage (EOC).

- c. Other dependent persons (but not including foster children) who meet all of the following requirements:
 - i. They are under the dependent limiting age shown in the "Schedule of Benefits (Who Pays What)"; and
 - ii. You or your Spouse is the court-appointed permanent legal guardian (or was before the person reached age 18)

EOC_POLICE(non-M)Ltr_Insert (01-26)

Page 1 of 1

**DENVER POLICE DEPARTMENT
MEDICARE EMPLOYEES
EVIDENCE OF COVERAGE AMENDMENT - 2026**

- I. The following eligibility and enrollment requirements are *in addition* to those detailed in this Evidence of Coverage (EOC), Eligibility and Enrollment section:**

ELIGIBILITY AND ENROLLMENT

Eligible Dependents

Dependent is any spouse, including those defined as common-law under the state, Spousal Equivalent, or child (including a step-child, child for whom the Insured Employee, their spouse, or Spousal Equivalent is required by a qualified medical child support order to provide health care coverage, even if the child does not reside at the same legal residence of the parent) meeting the Dependent Age Limits below. This includes unmarried incapacitated and physically disabled children who are legal dependents of the Insured Employee or legal dependents of a Spousal Equivalent of an Insured Employee, who meet the eligibility requirements set forth in the Summary Plan Description and Disclosure Form and for whom applicable Dues are received.

Dependent Child Age Limits: A child shall be covered to the end of the month that they turn age 26 and unmarried legal dependents who are mentally or physically disabled shall be covered regardless of age, all of whom must also be legal dependents of the Insured Employee, spouse or Spousal Equivalent.

Spousal equivalent is an adult with whom the employee is in an exclusive committed relationship, who is not related to the employee and who shares basic living expenses with the intent for the relationship to last indefinitely. A spousal equivalent cannot be related by blood to a degree which would prevent marriage in Colorado and cannot be married to another person. An employee claiming a spousal equivalent as an eligible dependent shall file with the Office of Human Resources employee benefits section, an affidavit of spousal equivalency, an affidavit of domestic partnership, or a civil union license.

- II. The following information is added and becomes part of this Evidence of Coverage (EOC):**

Employee Eligibility. An Eligible Member is a retired classified member of the Denver Police Department (Group), who is age 65 or older and who is eligible for Medicare ("Retiree"), and who meets any other eligibility requirements of the Group. Retirees must live in the Service Area.

The following conditions of enrollment and eligibility shall be applicable to subscribing Group in addition to the conditions specified above and in the attached Evidence of Coverage brochure. To the extent that any of the following conditions contradict those stated in the attached Evidence of Coverage brochure, the following shall prevail:

Eligibility Rules: No waiting period

Please NOTE that while active Police officers can live or work in the Service Area, Retirees MUST live in the Service Area.

EXHIBIT A-3
TO
AGREEMENT BETWEEN
CITY & COUNTY OF DENVER and
KAISER FOUNDATION HEALTH PLAN OF COLORADO

Exhibit A-3 Performance Metrics

1. 2026 Performance Guarantees — City and County of Denver
2. 2026 Performance Guarantees — Denver Police



2026 Performance Guarantees Agreement City and County of Denver

Guaranteed Performance

This Performance Guarantees Agreement is effective from January 1, 2026 through December 31, 2026.

Kaiser Permanente offers performance guarantees for its fully insured health plans backed by a percentage of the Customer's annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of the Customer's non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of the Customer's non-Medicare members will report performance without financial risk. In 2027, Kaiser Permanente will conduct a review of your 2026 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures

Some of Kaiser Permanente's measures or targets may change year-to-year based on medical or public health trends, performance enhancements, new systems implementation, and similar factors. In addition, some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA). If the measure is no longer reported, the definition of a measure changes, or if there are changes to reporting rules or publications after these guarantees are in place, Kaiser Permanente may no longer guarantee the measure.

Penalty Thresholds and Reporting Frequency

To the extent possible, Kaiser Permanente sets its penalty thresholds (i.e., the performance level Kaiser Permanente guarantees and below which Kaiser Permanente pays a penalty) in alignment with industry standards. Penalty thresholds for HEDIS measures are based on the applicable state/regional or national HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS results) Kaiser Permanente provides an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential

The information contained in this agreement is proprietary and confidential. Customer agrees to not share any information contained in this document with any Kaiser Permanente competitor, nor with any other third-party unless granted specific written consent to do so by Kaiser Permanente's representative.

Penalty Payments and Force Majeure

Kaiser Permanente reports performance results based on its annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on the Customer's total non-Medicare premium for the calendar year. Kaiser Permanente pays agreed-upon penalties by Automated Clearing House (ACH). The Customer is responsible for notifying its account management team of the correct banking information to which payment should be sent when processed.

Penalty payments on sample-based measures are contingent on statistically significant differences ('margins of error') from penalty thresholds. If the result on a measure is below the penalty threshold (target) Kaiser Permanente uses a standard statistical test to determine whether the difference is too large to be explained by random chance. Kaiser Permanente does not pay penalties unless the result is determined to be a true difference at the 95% or better confidence level.

If Kaiser Permanente is unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2026, in order to receive any penalty payments for missed performance measures due under this agreement. Kaiser Permanente requires that the Customer dispute any performance results and/or penalty due by submitting written notice to Kaiser Permanente within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser Permanente of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Customer written response must be received within 60 days of its receipt of Kaiser Permanente's final report or Customer will forfeit any penalties otherwise due to the Customer under this agreement.

Account Management Measures

Issues pertaining to satisfaction with account management are defined as matters that are under direct control of the Account Management Team (e.g., team availability, responses to customer questions, keeping customer informed of developments, etc.). Issues related to other health plan activities (e.g., pricing and rates, member call center services, claims, or eligibility processing) are not applicable to these measures and may be covered by other measures in this agreement.

Forfeiture on account management satisfaction measures is contingent on prompt notification (prior to September 1st of the agreement year) by the Customer of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of Kaiser Permanente account management to develop and execute on a corrective action plan constitutes failure on such measures.

To contact Kaiser Permanente

Thank you for giving Kaiser Permanente the opportunity to provide health care services to your employees and their families. Please contact the Customer Account Manager if there are questions or comments concerning this agreement.



2026 Performance Guarantees Agreement City and County of Denver

Based on projected 2025 membership, we expect the Colorado health plan will be guaranteed with premium at risk.

This Performance Guarantees Agreement is effective from January 1, 2026 through December 31, 2026.

Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except on measures where the penalty threshold is shown with a decimal point (e.g., ≤ 3.0%).

2026 Performance Measures		Penalty Threshold	Penalty (% of Premium)
<i>Member Services</i>			
1	City and County of Denver - Eligibility information available to medical groups within 8 business days	95%	0.07%
2	Average Speed to Live Voice	30 sec	0.07%
3	Telephone call abandonment rate	≤ 3.0%	0.07%
4	30 days)	80%	0.07%
5	KP.org web site availability (for non-secure sections, and excluding scheduled maintenance and downtime) - Kaiser national performance	98.5%	0.07%
<i>Member Satisfaction</i>			
6	Member satisfaction with health plan (CAHPS #31) ¹	≥ State Avg. ^{2*}	0.06%
<i>Account Management</i>			
7	Customer overall satisfaction with account management/team	Satisfied	0.11%
8	AM/team availability for periodic meetings and open enrollment (2-4 per year)	Meet	0.11%
9	AM/team response to client calls – within one business day	Meet	0.11%
<i>Claims</i>			
10	Claims Financial Accuracy	98.5%	0.08%
11	Claims Processing (financial incident) Accuracy	97%	0.08%
12	Claims Processing w/in 30 Calendar Days (clean claims)	95%	0.08%
<i>Quality of Care</i>			
13	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	≥ Natl. Avg. ^{3*}	0.07%
14	Cervical Cancer Screening Rate	≥ Natl. Avg. ^{3*}	0.07%
15	Colorectal Cancer Screening Rate	≥ Natl. Avg. ^{3*}	0.07%
16	Controlling High Blood Pressure – Total	≥ Natl. Avg. ^{3*}	0.07%
17	Appropriate Treatment for Upper Respiratory Infection (3mos -17yrs)	≥ Natl. Avg. ^{3*}	0.07%
18	Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy (Total)	≥ Natl. Avg. ^{3*}	0.07%
19	Eye Exam for Patients with Diabetes	≥ Natl. Avg. ^{3*}	0.07%
20	Blood Pressure Control for Patients with Diabetes	≥ Natl. Avg. ^{3*}	0.07%
21	Glycemic Status Assessment for Patients With Diabetes – poor control >9%	≤ Natl. Avg. ^{3*}	0.07%
22	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. Avg. ^{3*}	0.07%
23	Prenatal Care Rate	≥ Natl. Avg. ^{3*}	0.07%
24	Chlamydia Screening in Women (Total)	≥ Natl. Avg. ^{3*}	0.07%
<i>Accreditation and Reporting</i>			
25	NCQA Accreditation	Maintain	0.09%
26	HEDIS report available – within one month after NCQA public release of results	Report Available	0.09%
Total Percent at Risk			2.00%

¹ From the NCQA CAHPS Survey, based on the percent of respondents answering eight or higher on a 0 - 10 scale

² Based on NCQA's State/Regional HMO Average

³ Based on NCQA's National HMO Average

* Penalties are contingent on statistically significant differences from targets



2026 Performance Guarantees Agreement Denver Police

Guaranteed Performance

This Performance Guarantees Agreement is effective from January 1, 2026 through December 31, 2026.

Kaiser Permanente offers performance guarantees for its fully insured health plans backed by a percentage of the Customer's annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of the Customer's non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of the Customer's non-Medicare members will report performance without financial risk. In 2027, Kaiser Permanente will conduct a review of your 2026 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures

Some of Kaiser Permanente's measures or targets may change year-to-year based on medical or public health trends, performance enhancements, new systems implementation, and similar factors. In addition, some of the measures use definitions established by national organizations such as the National Committee for Quality Assurance (NCQA). If the measure is no longer reported, the definition of a measure changes, or if there are changes to reporting rules or publications after these guarantees are in place, Kaiser Permanente may no longer guarantee the measure.

Penalty Thresholds and Reporting Frequency

To the extent possible, Kaiser Permanente sets its penalty thresholds (i.e., the performance level Kaiser Permanente guarantees and below which Kaiser Permanente pays a penalty) in alignment with industry standards. Penalty thresholds for HEDIS measures are based on the applicable state/regional or national HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS results) Kaiser Permanente provides an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential

The information contained in this agreement is proprietary and confidential. Customer agrees to not share any information contained in this document with any Kaiser Permanente competitor, nor with any other third-party unless granted specific written consent to do so by Kaiser Permanente's representative.

Penalty Payments and Force Majeure

Kaiser Permanente reports performance results based on its annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on the Customer's total non-Medicare premium for the calendar year. Kaiser Permanente pays agreed-upon penalties by Automated Clearing House (ACH). The Customer is responsible for notifying its account management team of the correct banking information to which payment should be sent when processed.

Penalty payments on sample-based measures are contingent on statistically significant differences ('margins of error') from penalty thresholds. If the result on a measure is below the penalty threshold (target) Kaiser Permanente uses a standard statistical test to determine whether the difference is too large to be explained by random chance. Kaiser Permanente does not pay penalties unless the result is determined to be a true difference at the 95% or better confidence level.

If Kaiser Permanente is unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2026, in order to receive any penalty payments for missed performance measures due under this agreement. Kaiser Permanente requires that the Customer dispute any performance results and/or penalty due by submitting written notice to Kaiser Permanente within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser Permanente of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Customer written response must be received within 60 days of its receipt of Kaiser Permanente's final report or Customer will forfeit any penalties otherwise due to the Customer under this agreement.

Account Management Measures

Issues pertaining to satisfaction with account management are defined as matters that are under direct control of the Account Management Team (e.g., team availability, responses to customer questions, keeping customer informed of developments, etc.). Issues related to other health plan activities (e.g., pricing and rates, member call center services, claims, or eligibility processing) are not applicable to these measures and may be covered by other measures in this agreement.

Forfeiture on account management satisfaction measures is contingent on prompt notification (prior to September 1st of the agreement year) by the Customer of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of Kaiser Permanente account management to develop and execute on a corrective action plan constitutes failure on such measures.

To contact Kaiser Permanente

Thank you for giving Kaiser Permanente the opportunity to provide health care services to your employees and their families. Please contact the Customer Account Manager if there are questions or comments concerning this agreement.



2026 Performance Guarantees Agreement Denver Police

Based on projected 2025 membership, we expect the **Colorado** health plan will be guaranteed with premium at risk.

This Performance Guarantees Agreement is effective from January 1, 2026 through December 31, 2026.

Measures are based on annual, plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number except on measures where the penalty threshold is shown with a decimal point (e.g., ≤ 3.0%).

2026 Performance Measures		Penalty Threshold	Penalty (% of Premium)
<i>Member Services</i>			
1	Member service calls - percent answered within 30 seconds	80%	0.08%
2	Telephone call abandonment rate	≤ 3.0%	0.06%
3	Call Quality	85%	0.06%
4	Eligibility information available to medical groups within 8 business days (% of PG groups)	95%	0.06%
5	Premium/Eligibility reconciliation within 30 calendar days (% of PG groups) ¹	85%	0.06%
6	KP.org web site availability (for non-secure sections, and excluding scheduled maintenance and downtime) - Kaiser national performance	98.5%	0.06%
<i>Member Satisfaction</i>			
7	Member satisfaction with health plan (CAHPS #31) ²	≥ State Avg. ^{3*}	0.06%
<i>Account Management</i>			
8	Customer overall satisfaction with account management/team	Satisfied	0.10%
9	AM/team availability for periodic meetings and open enrollment (2-4 per year)	Meet	0.10%
10	AM/team response to client calls – within one business day	Meet	0.10%
<i>Quality of Care</i>			
11	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	≥ Natl. Avg. ^{4*}	0.09%
12	Cervical Cancer Screening Rate	≥ Natl. Avg. ^{4*}	0.09%
13	Colorectal Cancer Screening Rate	≥ Natl. Avg. ^{4*}	0.09%
14	Controlling High Blood Pressure – Total	≥ Natl. Avg. ^{4*}	0.09%
15	Appropriate Treatment for Upper Respiratory Infection (3mos -17yrs)	≥ Natl. Avg. ^{4*}	0.09%
16	Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy (Total)	≥ Natl. Avg. ^{4*}	0.09%
17	Eye Exam for Patients with Diabetes	≥ Natl. Avg. ^{4*}	0.09%
18	Blood Pressure Control for Patients with Diabetes	≥ Natl. Avg. ^{4*}	0.09%
19	Glycemic Status Assessment for Patients With Diabetes – poor control >9%	≤ Natl. Avg. ^{4*}	0.09%
20	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. Avg. ^{4*}	0.09%
21	Prenatal Care Rate	≥ Natl. Avg. ^{4*}	0.09%
22	Chlamydia Screening in Women (Total)	≥ Natl. Avg. ^{4*}	0.09%
<i>Accreditation and Reporting</i>			
23	NCQA Accreditation	Maintain	0.09%
24	HEDIS report available – within one month after NCQA public release of results	Report Available	0.09%
Total Percent at Risk			2.00%

¹ The 30-day calendar starts the day Kaiser Permanente has received both the premium and the premium report

² From the NCQA CAHPS Survey, based on the percent of respondents answering eight or higher on a 0 - 10 scale

³ Based on NCQA's State/Regional HMO Average

⁴ Based on NCQA's National HMO Average

* Penalties are contingent on statistically significant differences from targets