KAISER PERMANENTE®

Kaiser Foundation Health Plan of Colorado

A Colorado Nonprofit Corporation

2017

LARGE GROUP

GROUP AGREEMENT

City and County of Denver
Denver Fire Department
Denver Police Department

GROUP AGREEMENT

THIS AGREEMENT to purchase the attached insurance policies is made between the CITY AND COUNTY OF DENVER, a municipal corporation of the State of Colorado (the "City" or "Group") and Kaiser Foundation Health Plan of Colorado (the "Health Plan" or "Insurance Company" and together the "parties").

The parties agree as follows:

INTRODUCTION

For each Group, this Group Agreement ("*Agreement"*), including the Rate Sheet(s), the Evidence of Coverage (*"EOC"*) brochure(s), the Summary of Benefits and Coverage ("SBC"), Underwriting Assumptions and Requirements document, and the Performance Guarantees document (collectively attached hereto and incorporated herein as **Exhibit A**), and any amendments thereto, constitute the entire contract between the group named on the Rate Sheet ("Group") and Kaiser Foundation Health Plan of Colorado ("Health Plan").

In this *Agreement*, some capitalized terms have special meaning; please see the "Definitions" section in the *Evidence of Coverage* document for terms you should know.

Pursuant to this *Agreement,* Health Plan will provide covered Services to Members in accord with the *Evidence of Coverage.* If the insurance policy being purchased by the City requires approval by the Colorado Division of Insurance ("DOI"). If the insurance policy is pending DOI approval, the SBC and Performance Guarantees document are attached as evidence of the insurance policy coverage the City intends to purchase. Upon receipt of the DOI approved *EOC* (or Certificate of Coverage) the Executive Director of the Office of Human Resources or the Executive Director's designee ("**Executive Director**") shall file the approved insurance policy and *EOC* with the City's Clerk and Recorder to complete the public record for this *Agreement*.

Health Plan will provide Group with all internal policies which affect Member coverage under this *Agreement*. These policies will be disclosed to Group prior to the effective date of this *Agreement*.

If Group does not renew this *Agreement*, Group must give Health Plan written notice as described in the "Termination of *Agreement*" section.

WELLNESS PROGRAMS AND GROUP WELLNESS INVESTMENT FUNDS OR CREDITS

The Health Plan shall make available certain wellness programs ("**Wellness Programs**") for the Group to select from during the contract year. The Group's selection will be at the discretion of the Executive Director.

To facilitate efficient management and operation of the programs, the Health Plan will designate wellness investment "funds" or "credits" to be used in administering the selected Wellness Programs. Any reference to cash, payments or funds to be spent, charged or credited in each of the Wellness Program detail (attached as **Exhibits B** and **B-1**), shall be a reference to the credits or funds described

in this paragraph. The City shall not be liable for any other payment of funds to the Health Plan for the Wellness Programs selected.
At the discretion of the Executive Director, the Group can charge against the wellness investment funds or credits as allowed in each program description attached. The Health Plan Wellness Programs are:

1. Workforce Health Package Letter ("**Exhibit B**")
2. Kaiser Workforce Health Programs Document ("**Exhibit B-1**").
3. "Weigh and Win" program through an agreement with Incentahealth, LLC (Denver Contract # CSAHR-20162635.00).

WELLNESS PLATFORM SOFTWARE PAYMENT
The parties agree that the City needs to implement a wellness platform software to support the City employee wellness effort and successfully administer the City's wellness program through the use of centralized wellness data. For that reason, Insurance Company agrees to pay $200,000 to the workplace wellness software provider Viverae, Inc., for the purchase and implementation of a wellness platform software that the City will maintain. Such payment will be paid in full to Viverae, Inc. no more than 30 days after invoicing. Insurance Company agrees that the wellness platform software payment will not reduce the "funds" or "credits" used toward Wellness Programs, as defined herein, and further, the wellness platform software payment will not be funded through increased Group insurance premiums.

COORDINATION OF POLICY PURCHASE AND SIGNATURE AUTHORIZATION
The Insurance Company shall fully coordinate the purchase of agreed policies with the Executive Director. The Executive Director shall be authorized to sign documents listed in **Exhibit A**, hereto, and any other wellness and policy-related documents in Exhibit B, that are necessary for implementation or administration of the City's insurance program.

TERM OF *AGREEMENT* and RENEWAL
Term of Agreement
This *Agreement* is effective for the term beginning January 1, 2017, and ending at 11:59 p.m. on December 31, 2017, unless terminated as set forth in the "Termination of *Agreement*" section.

Renewal
This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew this *Agreement* either by sending Group a new *Agreement* to become effective immediately after termination of this *Agreement*, or by offering to extend the term of this *Agreement* pursuant to "Amendments Effective on an Anniversary Date" in the "Amendment of *Agreement*" section. The new or extended Agreement will include a new term of Agreement and other changes that are mutually agreed upon in writing by Health Plan and Group.

AMENDMENT OF *AGREEMENT*
Amendments Effective on an Anniversary Date
Upon 60 days prior written notice to Group with respect to proposed benefit or contract changes, or upon 30 days prior written notice to Group with respect to proposed rate changes, or as otherwise

agreed to by Health Plan and Group, Health Plan may offer to extend the term of this *Agreement* and propose amendments to this *Agreement* to be effective on any year's Anniversary Date (the Anniversary Date is shown on the Rate Sheet). Except as otherwise expressly stated in this *Agreement*, all amendments, including but not limited to benefit, contract and rate changes, must be mutually agreed upon in advance and in writing by Health Plan and Group.

Amendments Related to Government Approval or Mandated by Law
If Health Plan notified Group that Health Plan had not received all necessary government approvals related to this *Agreement*, Health Plan may propose to amend this *Agreement* by giving written notice to Group after receiving all necessary government approvals. Any such government-approved provisions go into effect on the Anniversary Date that next follows the Health Plan's original notice to Group of the provisions for which it had sought government approval (unless the government requires a later effective date), if the *Agreement* is renewed.

Amendment Due to Medicare Changes
Health Plan contracts on a calendar-year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this Agreement to change any Senior Advantage EOCs and Premiums effective January 1, 2017 (unless the federal government requires a different effective date). The amendment may include an increase or decrease in Premiums and Benefits including Member Cost Sharing and the Medicare Part D initial and catastrophic coverage levels; however, premium increases and Member Cost Sharing increases may not be made retroactive to a prior month. Health Plan will give Group at least 30 days advance written notice of any such amendment, so long as Health Plan is given 30 days' notice of such changes by CMS or other governmental entity.

Service Area
Health Plan may amend this *Agreement* at any time by giving written notice to Group, via certified mail, in order to expand the Health Plan Service Area.

TERMINATION OF *AGREEMENT*
This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end at 11:59 p.m. on the termination date, except as expressly provided in the *Evidence of Coverage*, and except as otherwise required by applicable law.

Health Plan will give Group written notice to the Executive Director and City Attorney's office at the addresses shown in the Notices section, via certified mail, if this *Agreement* terminates. Within five business days of receipt, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members
If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of

the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 30 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Dues, for the period prior to the termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective the anniversary date, if the anniversary date is the first of the month or the first of the month following the anniversary date if the anniversary date is not the first of the month, by giving at least 60 days prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Dues, for the period prior to the termination date.

Termination for Nonpayment

Health Plan may terminate this *Agreement* by giving advance written notice to Group, via certified mail, if Group fails to make any past-due Dues payment during Health Plan's grace period. The advance written notice will indicate the termination date. A grace period of 31 days is observed by Health Plan, during which time the amounts specified in the Rate Sheet may be paid by the Group without loss of benefits. The grace period shall apply to all payments except the first payment and coverage shall remain in effect if payment is made during the grace period. Group is liable for all unpaid Dues through the termination date. In the event that any Dues payment is not timely received by Health Plan, Health Plan will send the Group a notice of Dues owed. Such notice shall specify the delinquent Dues payment and the date upon which the 31 day grace period ends. Health Plan will give written notice to Group of final termination of this *Agreement* via certified mail.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members in order to comply with CMS termination notice requirements.

Termination for Fraud or for Intentionally Furnishing Materially Misleading or Fraudulent Information

If Group commits fraud or intentionally furnishes materially misleading or fraudulent information to Health Plan, Health Plan may terminate this *Agreement* by giving advance notice to the Group, and Group is liable for all unpaid Dues up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan's contribution or participation requirements as set forth in the "Contribution and Participation Requirements" section of this *Agreement*, Health Plan may terminate this *Agreement* by giving sixty (60) days advance written notice to Group, and Group is liable for all unpaid Dues up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Movement outside the Service Area
Health Plan may terminate this *Agreement* upon 30 days prior written notice, via certified mail, to Group if no eligible person lives, resides, or works in Health Plan's Service Area as described in the *Evidence of Coverage.*

Termination for Discontinuance of a Product or all Products within a Market
Health Plan may terminate a particular product or all products offered in the group market as permitted by law. If Health Plan discontinues offering a particular product in the group market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice, via certified mail, to Group. Health Plan will offer Group another product that it makes available in the group market. If Health Plan discontinues offering all products in the group market, Health Plan may terminate this *Agreement* upon 180 days written notice, via certified mail, to Group and Health Plan will not offer any other product to Group. A "product" is a combination of benefits and services that is defined by a distinct evidence of coverage.

DUES
Only Members for whom Health Plan has received the appropriate Dues payment listed on the Rate Sheet are entitled to coverage under this *Agreement*, and then only for the period for which Health Plan has received appropriate payment.
If Group does not prepay the Full Dues by the first of the coverage month or by the date otherwise agreed to by Health Plan and Group, the Dues may include an additional administrative charge upon renewal. "Full Dues" means 100 percent of monthly Dues for each enrolled Member, as set forth in this "Dues" section.

Dues Rebates
If state or federal law requires Health Plan to rebate dues from this or any earlier contract year and Health Plan rebates dues to Group, Group represents that Group will use that rebate in a manner consistent with the requirements of the Public Health Service Act, the Affordable Care Act, and the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

New Members
Dues are payable for the entire month for new Members unless otherwise agreed to by Health Plan.

Terminating Members

Pursuant to C.R.S. 10-16-103.5, dues are payable for each Member:

- Through the date that Health Plan receives written notice from Group that a Member is no longer eligible or covered; or

- Through the date that Health Plan receives written notice from Group that it no longer intends to maintain coverage for its Members through Health Plan.

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan 30 days prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or want Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if health Plan receives a termination notice on March 5, for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Dues for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination

If Health Plan receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

SUBSCRIBER CONTRIBUTIONS FOR MEDICARE PART C AND PART D COVERAGE

Medicare Part C Coverage

This "Subscriber Contributions for Medicare Part C Coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:

  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category

  - Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class.

- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C Premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium.

Medicare Part D Coverage

This "Subscriber Contributions for Medicare Part D Coverage" section, applies only to Group's Kaiser Permanente Senior Advantage coverage that includes Medicare Part D coverage. Group's Senior Advantage Dues include the Medicare Part D premium. Group may determine how much it will require Subscribers to contribute toward the Medicare Part D premium for each Senior Advantage Member in the Subscriber's Family Unit, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:

  - any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job Group will not require different Subscriber contributions toward the Medicare Part D category, and are not based on eligibility for the Part D Low Income Subsidy (a subsidy described in 42 C.F.R. 423 Subpart P, which is offered by the Medicare Program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduces the Medicare beneficiaries' Medicare Part D premiums or Medicare Part D cost-sharing amounts).
  - Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class.

- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member who exceeds the Dues for prescription drug coverage (including the Medicare Part D premium). The Group will pass through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premiums.

- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group's Members and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber's contribution for that Member's Senior Advantage premium for the same month, and will then apply any remaining portion of the Member's Low Income Subsidy toward the portion of the Senior Advantage premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber's contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers' monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance.

- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member's contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member's enrolling in the Member's current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount.

Late Enrollment Penalty
If any Members are subject to the Medicare Part D late enrollment penalty, Premiums for those Members will increase to include the amount of that penalty.

CONTRIBUTION AND PARTICIPATION REQUIREMENTS
No change in Group's contribution or participation requirements is effective for purposes of this *Agreement* unless Health Plan is timely notified in writing. If Group fails to satisfy the Contribution and Participation Requirements of this section, the Health Plan may terminate this *Agreement* as set forth in the **Termination for Violation of Contribution or Participation Requirements** in this *Agreement*.

The Group must:

- Contribute to all health care plans available through Group on a basis that does not financially discriminate against Health Plan or against people who choose to enroll in Health Plan.

- Ensure that:
  - All eligible employees enrolled in Health Plan meet the eligibility requirements of the Group.
  - All eligible employees enrolled in Health Plan are covered by Workers' Compensation, unless not required by law to be covered.
  - All Health Plan Subscribers live or work inside Health Plan's Service Area when they enroll.
  - The number of active, eligible employee Subscribers enrolled under this *Agreement* does not fall below 10.
  - There is a bona fide employer/employee relationship to those offered our plan, except eligible Taft-Hartley trusts and partnerships, and except as otherwise set forth in the agreed upon eligibility requirements.

- Hold an annual open enrollment period during which all eligible people may enroll in Health Plan or in any other health care plan available through Group.

- Meet all applicable legal and contractual requirements, such as:
  - Group must adhere to all requirements set forth in the applicable *Evidence of Coverage*, as amended.
  - Group must obtain Health Plan's prior written approval of any Group eligibility or participation or contribution requirements that are not stated in the applicable *Evidence of Coverage*, as amended.
  - Group must use Member enrollment application forms that are provided or approved by Health Plan.

- Comply with Centers for Medicare & Medicaid Services (CMS requirements governing enrollment in, and disenrollment from Kaiser Permanente Senior Advantage (KPSA).

- Meet all Health Plan requirements set forth in the "Underwriting Assumptions and Requirements" document, included in **Exhibit A**.

- Offer enrollment in Health Plan to all eligible people on conditions no less favorable than those for any other health care plan available through Group.

- Permit Health Plan to examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*, except as restricted by the laws of the City, State of Colorado law, or federal law.

LIABILITY INSURANCE

Health Plan shall, at its own cost and expense, maintain in full force and effect, during the term of this *Agreement*, professional (malpractice) and general liability insurance with minimum limits of at least $10,000,000 per occurrence. All such policies shall provide for the Group to receive at least thirty (30) days written notice from the insurance carrier or carriers prior to any cancellation or material change in any such policy. Health Plan shall provide to the Group, upon execution of this *Agreement*, and upon renewal of such insurance programs certificates of insurance for all such insurance carried. All insurance coverage must be written by companies authorized to do business in the State of Colorado. All such insurance shall cover claims occurring during the term of this *Agreement*, including claims which may be asserted after the termination of this *Agreement*.
Notwithstanding the foregoing, Health Plan may utilize a combination of insurance and alternative risk management programs, including self-insurance to provide for its contractual obligations under this *Agreement*. Evidence of such financial responsibility will be provided upon execution of this *Agreement.*

Insurance Company shall maintain Business Automobile Liability with limits of $1,000,000 combined single limit applicable to all owned, hired and non-owned vehicles used in performing services under this *Agreement*.

Each of the Health Plan's agreements with providers in its provider network does, and during the initial term and any renewal term of this *Agreement*, will require maintenance of levels of professional liability insurance consistent with industry standards and applicable law.

Health Plan covenants and agrees that at all times it will maintain and carry statutory workers' compensation insurance with an authorized insurance company or through an authorized self-insurance plan approved by the State of Colorado. Such insurance shall insure payment for such workers' compensation claims to all of Health Plan's employees, including specifically but not by way of limitation, all of its employees who in any manner perform work or provide services to fulfill Health Plan's obligations under this *Agreement*. Health Plan agrees to provide the Administrator with certificates, in number as required, satisfactorily evidencing the existence of the workers' compensation insurance.

There shall be a waiver of subrogation in favor of the City for Workers' Compensation and professional errors and omission coverage**.**

Insurance coverage specified herein constitutes the minimum requirements, and said requirements shall in no way lessen or limit the liability of Health Plan under the terms of the *Agreement*. Health Plan shall procure and maintain, at its own expense and cost, any additional kinds and amounts of insurance that, in its judgment, may be necessary for its proper protection in the prosecution of the services hereunder.

INDEMNIFICATION

Health Plan agrees to defend, release, indemnify and save and hold harmless the City, and its agents, officers and employees acting in their capacity as agents of the City against any and all claims, demands, costs (including reasonable attorney's fees) suits, actions, liabilities, causes of action or legal or equitable proceedings of any kind or nature, including workers' compensation claims, of or by anyone whomsoever, to the extent that they arise out of Health Plan's acts or omissions under this *Agreement*, including acts or omissions of Health Plan or to the extent that they are acting in their capacity as agents of Health Plan, its officers, employees, representatives, suppliers, invitees, licensees, subconsultants, subcontractors, and agents; provided, however, that Health Plan need not indemnify and save harmless the City, its officers, agents, and employees from damages arising out of the sole negligence of the City or the City's officers, agents, and employees acting in their capacity as agents of the City. This indemnity clause shall also cover the City's defense costs, in the event that the City, in its sole discretion, except as provided below, elects to provide its own defense. To the extent there is not a conflict, the City shall tender to Health Plan the opportunity, at Health Plan's expense, to arrange and direct the defense of any action or lawsuit related to the claim. If Health Plan accepts the tender, then Health Plan shall have no obligation to the City with respect to attorney's fees incurred by the City relating to the claim. Upon request, the City shall provide Health Plan all information and assistance reasonably necessary for the defense of the claim. In the event of a conflict and insurance counsel is needed, Health Plan will pay for separate counsel for the City. The City will select insurance counsel that normally or routinely works on insurance matters, and Health Plan may propose a list containing at least three (3) counsel alternatives from which the City may select.

PERFORMANCE GUARANTEES

The Performance Guarantees as set forth in the attached Performance Guarantees document included in **Exhibit A**, are expressly incorporated into this *Agreement*.

MISCELLANEOUS PROVISIONS

Acceptance of *Agreement*

Group acknowledges acceptance of this *Agreement* by signing one original Rate Sheet, with all signatures required by the Group, and returning it to Health Plan.

Note: Group and Heath Plan may not change this *Agreement* unilaterally by adding or deleting words, and any such addition or deletion is void. If Group wishes to change anything in this *Agreement*, Group must contact its Health Plan account manager, and Health Plan must contact the Group as set forth in the Amendments section of this *Agreement*. Health Plan will issue a new agreement or amendment if Health Plan and Group agree on any changes.

Assignment
Health Plan may not assign, transfer, pledge, or hypothecate in any way this *Agreement*. Group may not assign this *Agreement* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without Health Plan's prior written consent. Notwithstanding the foregoing, if Health Plan assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this *Agreement* will continue in full force and effect as if such corporation, firm or person were a party to this *Agreement*, provided that such corporation, firm or person continues to provide prepaid health services. No duties imposed by this *Agreement* be delegated without the approval of the other party, except that Health Plan may delegate certain functions, including but not limited to medical management, utilization review, credentialing and/or claims payment, to provider groups or other certified organizations which contract with Health Plan and that Health Plan may contract with its corporate affiliates to perform certain management and administrative services for Health Plan.

Certificates of Creditable Coverage
This "HIPAA Certificates of Creditable Coverage" section does not apply if Group has a written agreement with Health Plan that Group will mail certificates of creditable coverage.
If Group has a waiting period of affiliation period, when Group reports an enrollment of a new hire and any eligible Dependents who enroll at the same time (other than a Kaiser Permanente Senior Advantage enrollment) with a membership effective date that occurs during the term of this *Agreement*, Group must provide the following information in a format Health Plan approves:

- Enrollment reason. (If Group does not provide an enrollment reason, Health Plan will assume that Subscriber is not a new hire, and certificate for the Subscriber and any Dependents who enrolled at the same time will indicate that there was no waiting period or affiliation period.)
- Hire date of the Subscriber. (If the enrollment reason is "new hire" and Group does not provide a hire date, Health Plan will assume that the hire date is the effective date of coverage for the Subscriber and any Dependents who enrolled at the same time, and certificate for those Members will indicate there was no waiting period or affiliation period.)

- Effective date of coverage.

Group has a waiting period or affiliation period if the membership effective date for a new hire and any eligible Dependents who enroll at the same time is not the hire date (for example, if the membership effective date is the first of the month following the hire date).
Upon Health Plan request (whether or not Group has a waiting period of affiliation period), Group must provide any other information that Health Plan needs in order to complete certificates of creditable coverage.

When Health Plan mails a certificate of creditable coverage, the number of months of creditable coverage that Health Plan reports will be based on the information Health Plan has at the time the certificate is mailed.

Delegation of Claims Review Authority

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits, subject to the claims review process available to the Member or other actions permitted by law and this *Agreement*. For health benefit plans that are subject to the Employee Retirement Income Security Act (ERISA), Health Plan is a "named claims fiduciary" with respect to review of claims under this *Agreement.*

Governing Law

Except as preempted by federal law, this *Agreement* will be governed in accord with the laws of the State of Colorado and with the Charter and Revised Municipal Code of the City and County of Denver, and the ordinances, regulations, and Executive Orders enacted and/or promulgated pursuant thereto. The Charter and Revised Municipal Code of the City and County of Denver, as the same may be amended from time to time, are hereby expressly incorporated into this *Agreement* as if fully set out herein by this reference. Venue for any action brought as a result of this *Agreement* shall be in the District Court in and for the City and County of Denver. Any provision required to be in this *Agreement* by State of Colorado law or federal law shall bind Group and Health Plan whether or not set forth herein, and Health Plan will promptly notify Group if Health Plan discovers or has notice of any such provision.

Member Information

Group will inform Subscribers of eligibility requirements for Members and when coverage becomes effective and terminates.

When Health Plan notifies Group about proposed changes to this *Agreement*, or changes mandated by Governing Law above, or provides Group other information that affects Members, Group will disseminate the information to Subscribers by the next regular communication to them, but in no event later than 30 days after Group receives the information.

Group will provide electronic or paper summaries of benefits and coverage (SBCs) to participants and beneficiaries to the extent required by law, except that Health Plan will provide SBCs to Members who make a request to Health Plan.

Relationship of Parties

Group is not the agent or representative of Health Plan, and shall not be liable for any acts or omissions of Health Plan, its agents or its employees, or Plan Providers. Member is not the agent or representative of Health Plan, and shall not be liable for any acts or omissions of Health Plan, its agents or its employees. Plan Providers are independent contractors and are not the agents, employees or servants of Health Plan. It is understood and agreed by and between the parties that the status of Health Plan shall be that of an independent contractor and of a corporation retained on a contractual basis to perform professional or technical services for limited periods of time as described in Section 9.1.1 (E)(x) of the Charter of the City and it is not intended, nor shall it be construed, that Health Plan's personnel are employees or officers of the City under Chapter 18 of the Denver Revised Municipal Code or for any purpose whatsoever. Health Plan shall pay when due all required employment taxes and income tax withholding, shall provide and keep in force Workers' Compensation and unemployment compensation insurance in the amounts required by law.

Access to Books and Records
Health Plan and the Group shall have the right to access and examine the others' books and records for audit of compliance with the terms and conditions of this *Agreement*. Any such access shall not include the right to access any of Health Plan's books and records that would include protected health information about any of the Members in the Health Plan. However, Health Plan can provide the Group with those books and records to the extent personally identifiable information has been eliminated.
Health Plan agrees that it will keep and preserve for at least six (6) years after the final payment under this *Agreement* all directly pertinent books, documents, papers and records of Health Plan involving transactions related to this *Agreement.*

Confidentiality
Health Plan agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable Colorado State and federal laws, including HIPAA. However, Health Plan has access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this *Agreement* to Health Plan, its agents and employees, Plan Providers, and appropriate governmental agencies, to the extent permitted by HIPAA. Health Plan will not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received Covered Services, unless authorized to do so by the Member. Except as necessary to effectuate this *Agreement*, but only to the extent permitted by HIPAA and applicable Colorado law, Health Plan shall not at any time or in any manner, either directly or indirectly, divulge, disclose or communicate to any person, firm or corporation in any manner whatsoever any information which is not subject to public disclosure, including without limitation the trade secrets of business or entities doing business with the Group, the data contained in any of the data bases of the Group, and other privileged or confidential information. This obligation shall survive the termination of this *Agreement*. Health Plan shall advise its employees, agents and subcontractors, if any, that they are subject to these confidentiality requirements. Further Health Plan shall provide its employees, agents and subcontractors, if any, with a copy or written explanation of these confidentiality requirements before access to confidential data is permitted.

No Waiver
Health Plan's failure and Group's failure to enforce any provision of this *Agreement* will not constitute a waiver of that or any other provision, or impair Health Plan's or Group's right thereafter to require strict performance of any provision.

Notices
Notices must be delivered in writing to the address listed below, except that

- Health Plan and Group may each change its notice address by giving written notice, via certified mail, to the other.

Notices are to be sent via certified mail and are deemed given when delivered in person or deposited in a U.S. Postal Service receptacle for the collection of U.S. mail.

Notices from Health Plan to Group:

Executive Director
Office of Human Resources
201 W. Colfax Ave., Dept. 412
Denver, CO 80202

Notices from Group to Health Plan:

Kaiser Foundation Health Plan of Colorado
2500 South Havana Street
Aurora, Colorado 80014-1622

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll under the terms of a group health plan can become effective, in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

Social Security and Tax Identification Numbers

Within 30 – 60 days after Health Plan sends a Group a written request, Group will send Health Plan a list of all Members covered under this Group Agreement, along with the following:

- The Member's Social Security number,
- The tax identification number of the employer of the Subscriber in the Member's Family Unit,
- Any other information that Health Plan is required by law to collect.

Time Limit on Reporting Membership Changes

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. The time limit for retroactive membership additions is the calendar month when Health Plan receives Group's notification of the change plus the previous two months, unless Health Plan agrees otherwise in writing.

Involuntary Kaiser Permanente Senior Advantage Membership Termination

Group must give Health Plan 30 days prior written notice of Senior Advantage Medicare Plus involuntary membership terminations. An involuntary membership termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan receives a Senior Advantage Medicare Plus membership termination notice unless Group specifies a later termination date. For example, if Health Plan receives a termination notice on March 5 for a Senior Advantage Medicare Plus Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Termination
If Health Plan receives a disenrollment notice from CMS or membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

The administration of COBRA and State Continuation of Coverage participants will be in accord with applicable Federal and State laws.

Colorado Governmental Immunity Act
The parties hereto understand and agree that the Group is relying upon, and has not waived, the monetary limitations and all other rights, immunities and protection provided by the Colorado Governmental Immunity Act, C.R.S. §24-10-101 et seq.

Conflict of Interest
The parties agree that no employee of the Group shall have any personal or beneficial interest whatsoever in the services or property described herein and Health Plan further agrees not to hire or contract for the services of any employee or officer of the Group which would be in violation of the Denver Revised Municipal Code Chapter 2, Article IV, Code of Ethics, or Denver City Charter Sections 1.2.9 and 1.2.12.

Severability
It is understood and agreed by the parties hereto that if any part, term, or provision of this *Agreement*, except for the provisions of this *Agreement* requiring prior appropriation of funds and limiting the total amount payable by the Group, is held to be unenforceable for any reason, or in conflict with any law of the State of Colorado, the validity of the remaining portions or provisions shall not be affected, and the rights and obligations of the parties shall be construed and enforced as if this *Agreement* did not contain the particular part, term, or provision held to be invalid.

Survival of Certain Agreement Provisions
The parties understand and agree that all terms and conditions of this *Agreement*, together with the exhibits and attachments hereto, if any, any or all of which, by reasonable implication, contemplate continued performance or compliance beyond the expiration or termination of this *Agreement* (by expiration of the term or otherwise), shall survive such expiration or termination and shall continue to be enforceable as provided herein.

Appropriation Required and Contract Maximum
Notwithstanding any other term, condition, or covenant hereof, it is understood and agreed that any payment obligation of the Group hereunder, whether direct or contingent, shall extend only to funds appropriated by the Denver City Council for the purpose of this *Agreement*, encumbered for the purpose of this *Agreement* and paid into the Treasury of the City and County of Denver. Health Plan acknowledges that (i) the Group does not by this *Agreement* irrevocably pledge present cash reserves for payments in future fiscal years, and (ii) this *Agreement* is not intended to create a multiple-fiscal year direct or indirect debt or financial obligation of the Group. The maximum contract amount for the Group's obligations under this *Agreement* and for payment of Dues, collectively, shall not exceed [] unless additional appropriation is made by Group and this *Agreement* is amended by the parties pursuant

to the **Amendment of *Agreement*** section of this *Agreement*. If Group fails to pay Dues within the grace period, Health Plan may exercise its rights under the **Termination for Nonpayment** section of this *Agreement* or other applicable rights of Health Plan under this *Agreement*. Only Enrollees for whom Dues are received by Health Plan are entitled to health care benefits as described in this *Agreement*, and then only for the period for which such payment is received, except as otherwise required by law.

No Employment of Illegal Aliens to Perform Work under the Agreement.
This Agreement is subject to Division 5 of Article IV of Chapter 20 of the Denver Revised Municipal Code, as may be amended from time to time (the "Certification Ordinance"). The Health Plan certifies that: at the time of its execution of this Agreement, it does not knowingly employ or contract with an illegal alien who will perform work under this Agreement, and that Health Plan will participate in the E-Verify Program, as defined in § 8-17.5-101(3.7), C.R.S., to confirm the employment eligibility of all employees who are newly hired for employment to perform work under this Agreement.
Health Plan also agrees and represents that Health Plan:

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

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

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

(4) is prohibited from using either the E-Verify Program procedures to undertake pre-employment screening of job applicants while performing its obligations under the Agreement, and it is required to comply with any and all federal requirements related to use of the E-Verify Program including, by way of example, all program requirements related to employee notification and preservation of employee rights;

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

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

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

Grant of Limited License to Use Logo.
The City hereby grants to Health Plan, subject to the terms and conditions set forth herein, a non-exclusive, nontransferable limited license, to use the "Denver D" logo ("**Denver Logo**") during the Term of this Agreement. Health Plan shall fully coordinate all logo use under this Agreement with the Denver Marketing Office ((720) 913-1633, denvermarketingoffice@denvergov.org), or otherwise as directed by the City. The use of the Denver Logo is limited to display on the website to be created by Health Plan pursuant to this Agreement and for the purpose of identification only.

Health Plan shall display the Denver Logo in a read-only format and shall not be used or displayed on the website in any format from which it can be downloaded, copied or reproduced in any manner. The license granted by the City is non-transferable and non-assignable to anyone other than those acting under the supervision and authority of Health Plan.

Health Plan shall be solely responsible for the entire cost and expense of Health Plan's Use of the Denver Logo. The Denver Logo may not be used as a feature or design element of any other logo or graphic. Health Plan shall use the Denver Logo in accordance with any and all logo usage guidelines in effect from time-to-time as provided by the City. Health Plan shall use only accurate reproductions of the Denver Logo. The size, proportions, colors, elements, and other distinctive characteristics of the Denver Logo shall not be altered in any manner except as may be permitted herein or as permitted in writing by the City. Health Plan may use the colors set forth in the "Denver Logo Guidelines" document, (attached hereto as "**Exhibit C**").

Health Plan shall affix a trademark ("™") or registration ("®") indication next to the Denver Logo as directed by the Denver Marketing Office. Health Plan shall immediately cease all use of the Denver Logo upon expiration of the Term of this Agreement, as may have been extended from time to time by the parties, in a formal written extension of this Agreement.

Exhibit List:

Exhibit A - EOC Brochure, Summary of Benefits and Coverage & Performance Guarantees

Exhibit B - Wellness Programs

Exhibit C - Denver Logo Guidelines

[REMAINDER OF PAGE INTENTIONALLY LEFT BLANK]

[*The City's Contract System Will Produce Signature Blocks to be Inserted*]

Contract Control Number:

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:

By_____

By_____

By_____

Contract Control Number: CSAHR-201631061-00

Contractor Name: Kaiser Foundation Health Plan of Colorado

By:  _____

Name: R. Roland Lyon
(please print)

Title: President
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A

2017 KAISER PERMANENTE

Rate Sheet(s)
Evidence of Coverage
Summary of Benefits and Coverage ("SBC")
Underwriting Assumptions Requirements document
Performance Guarantees Document

EXHIBIT A

2017 KAISER PERMANENTE

RATE SHEETS

For

City and County of Denver Employees
Denver Fire Department
Denver Police Department

EXHIBIT A

2017 KAISER PERMANENTE

CITY AND COUNTY OF DENVER
RATE SHEETS

Group Name: CITY AND COUNTY OF DENVER Group Number: 75

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
050	CITY AND CNTY OF DEN ACT DHMO	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
051	C&C DENVER-DHMO-CB-DB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
052	C&C DENVER-DHMO-RT-DB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
053	C&C DENVER-DHMO-AC-CS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
054	C&C DENVER-DHMO-CB-CS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
055	C&C DENVER-DHMO-RT-CS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
056	C&C DENVER-DHMO-AC-PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
057	C&C DENVER-DHMO-CB-PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
058	C&C DENVER-DHMO-RT-PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
059	C&C DENVER-DHMO-RT-NC	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
060	C&C DENVER-DHMO-AC-NC	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
061	C&C DENVER-DHMO-CB-NC	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Steps	Total
Employee Only	493.32
Spouse Only	493.32
Child Only	493.32
Employee & Spouse	1085.3
Employee & Child	986.63
Spouse & Child	986.63
Children Only (CK)	986.63
Employee, Spouse & Child/Children	1578.61
Employee & Children (ECK+)	986.63
Spouse & Children (SCK+)	986.63
Children Only (CKK+)	986.63

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: CITY AND COUNTY OF DENVER Group Number: 75

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
050	CITY AND CNTY OF DEN ACT DHMO	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
051	C&C DENVER-DHMO-CB-DB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
052	C&C DENVER-DHMO-RT-DB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
053	C&C DENVER-DHMO-AC-CS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
054	C&C DENVER-DHMO-CB-CS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
055	C&C DENVER-DHMO-RT-CS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
056	C&C DENVER-DHMO-AC-PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
057	C&C DENVER-DHMO-CB-PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
058	C&C DENVER-DHMO-RT-PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
059	C&C DENVER-DHMO-RT-NC	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
060	C&C DENVER-DHMO-AC-NC	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
061	C&C DENVER-DHMO-CB-NC	Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Plan /ENTL	Total
Medicare Risk AB	226.33
Medicare Risk B	577.93
Medicare Risk BD	577.93
Medicare Risk CD	226.33

Group Name: CITY AND COUNTY OF DENVER Group Number: 75

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
013	C&C OF DENVER HDHP DB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
014	C&C OF DENVER HDHP RT	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
015	C&C OF DENVER HDHP CB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
033	C&C DENVER-HDHP-AC-PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
034	C&C DENVER-HDHP-RT-PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
035	C&C DENVER-HDHP-CB-PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
043	C&C DENVER-HDHP-AC-NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
044	C&C DENVER-HDHP-RT-NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
045	C&C DENVER-HDHP-CB-NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
065	C&C DENVER-HDHP-AC-CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
066	C&C DENVER-HDHP-RT-CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
067	C&C DENVER-HDHP-CB-CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF

Steps	Total
Employee Only	397.9
Spouse Only	397.9
Child Only	397.9
Employee & Spouse	875.38
Employee & Child	795.8
Spouse & Child	795.8
Children Only (CK)	795.8
Employee, Spouse & Child/Children	1273.28
Employee & Children (ECK+)	795.8
Spouse & Children (SCK+)	795.8
Children Only (CKK+)	795.8

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: CITY AND COUNTY OF DENVER Group Number: 75

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
013	C&C OF DENVER HDHP DB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
014	C&C OF DENVER HDHP RT	Medicare	EMAB	DED W/HSA 20% COIN M NGF
015	C&C OF DENVER HDHP CB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
033	C&C DENVER-HDHP-AC-PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
034	C&C DENVER-HDHP-RT-PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
035	C&C DENVER-HDHP-CB-PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
043	C&C DENVER-HDHP-AC-NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
044	C&C DENVER-HDHP-RT-NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
045	C&C DENVER-HDHP-CB-NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
065	C&C DENVER-HDHP-AC-CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF
066	C&C DENVER-HDHP-RT-CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF
067	C&C DENVER-HDHP-CB-CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF

Plan /ENTL	Total
Medicare Risk AB	226.33
Medicare Risk B	577.93
Medicare Risk BD	577.93
Medicare Risk CD	226.33

Group Name: CITY AND COUNTY OF DENVER Group Number: 75

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name

EXHIBIT A

2017 KAISER PERMANENTE

DENVER FIRE DEPARTMENT
RATE SHEETS

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
027	DFD-HMOMED-RETBASE-POS65-DB	Non Medicare	EMBD	$20 OVC HMO M NGF
030	DFD-HMOMED-RETBASE-POS65-CE	Non Medicare	EMBD	$20 OVC HMO M NGF
033	DENVER FIRE COS POST 65 BASE	Non Medicare	EMBD	$20 OVC HMO M NGF
037	DFD-HMOMED-RETBASE-POS65-NC	Non Medicare	EMBD	$20 OVC HMO M NGF

Steps	Total
Employee Only	541
Spouse Only	541
Child Only	541
Employee & Spouse	1108
Employee & Child	1081
Spouse & Child	1081
Children Only (CK)	1081
Employee, Spouse & Child/Children	1563
Employee & Children (ECK+)	1081
Spouse & Children (SCK+)	1081
Children Only (CKK+)	1081

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
027	DFD-HMOMED-RETBASE-POS65-DB	Medicare	EMBD	$20 OVC HMO M NGF
030	DFD-HMOMED-RETBASE-POS65-CE	Medicare	EMBD	$20 OVC HMO M NGF
033	DENVER FIRE COS POST 65 BASE	Medicare	EMBD	$20 OVC HMO M NGF
037	DFD-HMOMED-RETBASE-POS65-NC	Medicare	EMBD	$20 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	165.82
Medicare Risk B	517.42
Medicare Risk BD	517.42
Medicare Risk CD	165.82

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
019	DFD-HMOMED-RETLOW-POS65-DB	Non Medicare	EMBD	$20 OVC HMO M NGF
028	DFD-HMOMED-RETLOW-POS65-CE	Non Medicare	EMBD	$20 OVC HMO M NGF
032	DFD-HMOMED-RETLOW-POS65-CS	Non Medicare	EMBD	$20 OVC HMO M NGF
039	DFD-HMOMED-RETLOW-POS65-NC	Non Medicare	EMBD	$20 OVC HMO M NGF

Steps	Total
Employee Only	541
Spouse Only	541
Child Only	541
Employee & Spouse	1108
Employee & Child	1081
Spouse & Child	1081
Children Only (CK)	1081
Employee, Spouse & Child/Children	1563
Employee & Children (ECK+)	1081
Spouse & Children (SCK+)	1081
Children Only (CKK+)	1081

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
019	DFD-HMOMED-RETLOW-POS65-DB	Medicare	EMBD	$20 OVC HMO M NGF
028	DFD-HMOMED-RETLOW-POS65-CE	Medicare	EMBD	$20 OVC HMO M NGF
032	DFD-HMOMED-RETLOW-POS65-CS	Medicare	EMBD	$20 OVC HMO M NGF
039	DFD-HMOMED-RETLOW-POS65-NC	Medicare	EMBD	$20 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	204.48
Medicare Risk B	556.08
Medicare Risk BD	556.08
Medicare Risk CD	204.48

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
002	DFD-HMOMED-RETHI-PRE65-DB	Non Medicare	EMBD	$20 OVC HMO M NGF
025	DFD-HMOMED-RETHI-POST65-DB	Non Medicare	EMBD	$20 OVC HMO M NGF
029	DFD-HMOMED-RETHI-PRE65-CE	Non Medicare	EMBD	$20 OVC HMO M NGF
031	DFD-HMOMED-RETHI-PRE65-CS	Non Medicare	EMBD	$20 OVC HMO M NGF
036	DFD-HMOMED-RETHI-PRE65-NC	Non Medicare	EMBD	$20 OVC HMO M NGF

Steps	Total
Employee Only	541
Spouse Only	541
Child Only	541
Employee & Spouse	1108
Employee & Child	1081
Spouse & Child	1081
Children Only (CK)	1081
Employee, Spouse & Child/Children	1563
Employee & Children (ECK+)	1081
Spouse & Children (SCK+)	1081
Children Only (CKK+)	1081

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
002	DFD-HMOMED-RETHI-PRE65-DB	Medicare	EMBD	$20 OVC HMO M NGF
025	DFD-HMOMED-RETHI-POST65-DB	Medicare	EMBD	$20 OVC HMO M NGF
029	DFD-HMOMED-RETHI-PRE65-CE	Medicare	EMBD	$20 OVC HMO M NGF
031	DFD-HMOMED-RETHI-PRE65-CS	Medicare	EMBD	$20 OVC HMO M NGF
036	DFD-HMOMED-RETHI-PRE65-NC	Medicare	EMBD	$20 OVC HMO M NGF

Plan /ENTL	Total
Medicare Risk AB	343.63
Medicare Risk B	695.23
Medicare Risk BD	695.23
Medicare Risk CD	343.63

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
001	DFD-HMO-ACT-DB	Non Medicare	ENAB	$20 OVC HMO NM NGF
003	DFD-HMO-CB-DB	Non Medicare	ENAB	$20 OVC HMO NM NGF
005	DFD-HMO-RET-PRE65-CS	Non Medicare	ENAB	$20 OVC HMO NM NGF
007	DFD-HMO-ACT-CS	Non Medicare	ENAB	$20 OVC HMO NM NGF
012	DFD-HMO-CB-CS	Non Medicare	ENAB	$20 OVC HMO NM NGF
026	DFD-HMO-RET-PRE65-CE	Non Medicare	ENAB	$20 OVC HMO NM NGF
034	DFD-HMO-ACT-NC	Non Medicare	ENAB	$20 OVC HMO NM NGF
035	DFD-HMO-CB-NC	Non Medicare	ENAB	$20 OVC HMO NM NGF

Steps	Total
Employee Only	541
Spouse Only	541
Child Only	541
Employee & Spouse	1108
Employee & Child	1081
Spouse & Child	1081
Children Only (CK)	1081
Employee, Spouse & Child/Children	1563
Employee & Children (ECK+)	1081
Spouse & Children (SCK+)	1081
Children Only (CKK+)	1081

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
013	DFD-POS3OPT-ACT-DB	Non Medicare	ENAB	$20 OVC HMO NM NGF
014	DFD-POS3OPT-RET-PRE65-DB	Non Medicare	ENAB	$20 OVC HMO NM NGF
016	DFD-POS3OPT-CB-DB	Non Medicare	ENAB	$20 OVC HMO NM NGF
038	DFD-POS3OPT-ACT-NC	Non Medicare	ENAB	$20 OVC HMO NM NGF
058	DFD-POS3OPT-CB-NC	Non Medicare	ENAB	$20 OVC HMO NM NGF
062	DENVER FIRE DEPT DFD POS3 T1 C	Non Medicare	ENAB	$20 OVC HMO NM NGF
064	DENVER FIRE 3POS PB/AC	Non Medicare	ENAB	$20 OVC HMO NM NGF
C62	DENVER FIRE DEPT DFD POS3	Non Medicare	ENAB	$20 OVC HMO NM NGF
C64	DENVER FIRE 3POS T1 PB/CB	Non Medicare	ENAB	$20 OVC HMO NM NGF

Steps	Total
Employee Only	656
Spouse Only	656
Child Only	656
Employee & Spouse	1346
Employee & Child	1313
Spouse & Child	1313
Children Only (CK)	1313
Employee, Spouse & Child/Children	1896
Employee & Children (ECK+)	1313
Spouse & Children (SCK+)	1313
Children Only (CKK+)	1313

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
040	DFD-HDHP-ACT-DB	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
041	DFD-HDHP-CB-DB	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
042	DFD-HDHP-RETHI-PRE65-DB	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
043	DFD-HDHP-ACT-CS	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
044	DFD-HDHP-CB-CS	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
045	DFD-HDHP-RETHI-PRE65-CS	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
046	DFD-HDHP-ACT-CE	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
047	DFD-HDHP-CB-CE	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
048	DFD-HDHP-RETHI-PRE65-CE	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
049	DFD-HDHP-ACT-NC	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
050	DFD-HDHP-CB-NC	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
051	DFD-HDHP-RETHI-PRE65-NC	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
054	DFD-HDHP2-ACT-CS	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
055	DFD-HDHP2-CB-CS	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
056	DFD-HDHP2-ACT-CE	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
057	DFD-HDHP2-CB-CE	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
059	DFD-HDHP2-RETHI-PRE65-CS	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF
060	DFD-HDHP2-RETHI-PRE65-CE	Non Medicare	ENBC	DED W/HSA 20% COIN NM NGF

Steps	Total
Employee Only	400
Spouse Only	400
Child Only	400
Employee & Spouse	821
Employee & Child	802
Spouse & Child	802
Children Only (CK)	802
Employee, Spouse & Child/Children	1157
Employee & Children (ECK+)	802
Spouse & Children (SCK+)	802
Children Only (CKK+)	802

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
061	DENVER FIRE OOA-PPO	Non Medicare	PV15	40% TRADTNL PPO - LG HCR

Steps	Total
Employee Only	656
Spouse Only	656
Child Only	656
Employee & Spouse	1346
Employee & Child	1313
Spouse & Child	1313
Children Only (CK)	1313
Employee, Spouse & Child/Children	1896
Employee & Children (ECK+)	1313
Spouse & Children (SCK+)	1313
Children Only (CKK+)	1313

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER FIRE DEPARTMENT Group Number: 74

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name

EXHIBIT A

2017 KAISER PERMANENTE

DENVER POLICE DEPARTMENT
RATE SHEETS

Group Name: DENVER POLICE DEPARTMENT Group Number: 68

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
030	DENVER POLICE ACT DHMO DB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
031	DENVER POLICE COBRA DHMO DB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
032	DENVER POLICE RETIREE DHMO DB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
033	DENVER POLICE ACTIVE DHMO COS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
034	DENVER POLICE COBRA DHMO COS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
035	DENVER POLICE RETIREE DHMO COS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
036	DENVER POLICE ACTIVE DHMO PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
037	DENVER POLICE COBRA DHMO PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
038	DENVER POLICE RETIREE DHMO PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
039	DENVER POLICE ACTIVE DHMO NOCO	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
040	DENVER POLICE COBRA DHMO NOCO	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
041	DENVER POLICE RETIREE DHMO NC	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
042	DENVER POLICE RETIREE COBRA DB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
043	DENVER POLICE RET COB DHMO COS	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
044	DENVER POLICE RET COB DHMO PB	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG
045	DENVER POLICE RET COB DHMO NC	Non Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Steps	Total
Employee Only	393.05
Spouse Only	393.05
Child Only	393.05
Employee & Spouse	864.74
Employee & Child	786.09
Spouse & Child	786.09
Children Only (CK)	786.09
Employee, Spouse & Child/Children	1257.74
Employee & Children (ECK+)	786.09
Spouse & Children (SCK+)	786.09
Children Only (CKK+)	786.09

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER POLICE DEPARTMENT Group Number: 68

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
030	DENVER POLICE ACT DHMO DB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
031	DENVER POLICE COBRA DHMO DB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
032	DENVER POLICE RETIREE DHMO DB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
033	DENVER POLICE ACTIVE DHMO COS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
034	DENVER POLICE COBRA DHMO COS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
035	DENVER POLICE RETIREE DHMO COS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
036	DENVER POLICE ACTIVE DHMO PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
037	DENVER POLICE COBRA DHMO PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
038	DENVER POLICE RETIREE DHMO PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
039	DENVER POLICE ACTIVE DHMO NOCO	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
040	DENVER POLICE COBRA DHMO NOCO	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
041	DENVER POLICE RETIREE DHMO NC	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
042	DENVER POLICE RETIREE COBRA DB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
043	DENVER POLICE RET COB DHMO COS	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
044	DENVER POLICE RET COB DHMO PB	Medicare	EM1C	EB-20% COINS HMO PLAN-LG
045	DENVER POLICE RET COB DHMO NC	Medicare	EM1C	EB-20% COINS HMO PLAN-LG

Plan /ENTL	Total
Medicare Risk AB	252.61
Medicare Risk B	604.21
Medicare Risk BD	604.21
Medicare Risk CD	252.61

Group Name: DENVER POLICE DEPARTMENT Group Number: 68

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
050	DENVER POLICE ACTIVES HDHP DB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
051	DENVER POLICE RETIREES HDHP DB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
052	DENVER POLICE COBRA HDHP DB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
053	DENVER POLICE RET COB HDHP DB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
060	DENVER POLICE ACTIVE HDHP CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
061	DENVER POLICE RETIREE HDHP CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
062	DENVER POLICE COBRA HDHP CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
063	DENVER POLICE RET COB HDHP CS	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
070	DENVER POLICE ACTIVE HDHP PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
071	DENVER POLICE RETIREE HDHP PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
072	DENVER POLICE COBRA HDHP PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
073	DENVER POLICE RET COB HDHP PB	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
080	DENVER POLICE ACTIVE HDHP NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
081	DENVER POLICE RETIREE HDHP NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
082	DENVER POLICE COBRA HDHP NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF
083	DENVER POLICE RET COB HDHP NC	Non Medicare	EMAB	DED W/HSA 20% COIN M NGF

Steps	Total
Employee Only	379.67
Spouse Only	379.67
Child Only	379.67
Employee & Spouse	831.74
Employee & Child	756
Spouse & Child	756
Children Only (CK)	756
Employee, Spouse & Child/Children	1207.62
Employee & Children (ECK+)	756
Spouse & Children (SCK+)	756
Children Only (CKK+)	756

NOTE: Employees and their spouses age 65 and over who are entitled to Medicare benefits, but who elect this coverage as their primary health coverage pursuant to the applicable provisions of federal law, will be considered for purposes of rates as members under age 65 who are not entitled to Medicare.

Group Name: DENVER POLICE DEPARTMENT Group Number: 68

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name
050	DENVER POLICE ACTIVES HDHP DB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
051	DENVER POLICE RETIREES HDHP DB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
052	DENVER POLICE COBRA HDHP DB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
053	DENVER POLICE RET COB HDHP DB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
060	DENVER POLICE ACTIVE HDHP CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF
061	DENVER POLICE RETIREE HDHP CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF
062	DENVER POLICE COBRA HDHP CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF
063	DENVER POLICE RET COB HDHP CS	Medicare	EMAB	DED W/HSA 20% COIN M NGF
070	DENVER POLICE ACTIVE HDHP PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
071	DENVER POLICE RETIREE HDHP PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
072	DENVER POLICE COBRA HDHP PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
073	DENVER POLICE RET COB HDHP PB	Medicare	EMAB	DED W/HSA 20% COIN M NGF
080	DENVER POLICE ACTIVE HDHP NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
081	DENVER POLICE RETIREE HDHP NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
082	DENVER POLICE COBRA HDHP NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF
083	DENVER POLICE RET COB HDHP NC	Medicare	EMAB	DED W/HSA 20% COIN M NGF

Plan /ENTL	Total
Medicare Risk AB	252.61
Medicare Risk B	604.21
Medicare Risk BD	604.21
Medicare Risk CD	252.61

Group Name: DENVER POLICE DEPARTMENT Group Number: 68

Contract Period: 1/1/2017 - 12/31/2017

Sub Group	Sub Group Name	Non Medicare Medicare	Plan ID	Plan Name

EXHIBIT A

2017 KAISER PERMANENTE

EVIDENCE OF COVERAGE ("EOC") DOCUMENTS

NOTE: AS OF THE TIME OF PROCESSING THIS AGREEMENT, THE EOC'S ARE PENDING STATE APPROVAL AND WILL BE ATTACHED TO THIS AGREEMENT AT A LATER TIME

EXHIBIT A

2017 KAISER PERMANENTE

Denver Fire Department Point of Service Plan

40264 Summary of Benefits Coverage

*The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network portion is underwritten by KPIC, a subsidiary of KFHP.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Plan provider: **$0**; PAR provider: **$300** individual / **$900** family; Non-PAR provider: **$400** individual / **$1,200** family. Does not apply to preventive care services, services with copays and prescription drugs.	Plan provider: See the chart starting on page 2 for costs for services this plan covers. PAR and Non-PAR provider: You must pay all costs up to the **deductible** amount before plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	Plan provider: No PAR provider: No; Non-PAR provider: No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers**.**
Is there an out–of–pocket limit on my expenses?	Yes, Plan provider: **$2,000** individual / **$3,500** family; PAR provider: **$3,000** individual **/ $9,000** family; Non-PAR provider: **$6,000** individual **/ $18,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges and health care this plan doesn't cover; (certain services may not apply to the out-of-pocket maximum).	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 711)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay each visit	$20 copay per visit (20% coinsurance for covered services received during a visit)	40% coinsurance	PAR provider: copay not subject to the deductible; diagnostic lab and x-ray services performed in the office are not subject to coinsurance.
	Specialist visit	$30 copay per visit	$35 copay per visit (20% coinsurance for covered services received during a visit)	40% coinsurance	PAR provider: copay not subject to the deductible; diagnostic lab and x-ray services performed in the office are not subject to coinsurance.
	Other practitioner office visit	$20 copay each visit for Chiropractic care. Acupuncture services not covered.	$35 copay per visit for Chiropractic care. Acupuncture services not covered.	Not covered	PAR provider: copay not subject to the deductible; 20 visits per year; limited to Chiropractic care only. Plan provider: 20 visits per year for Chiropractic care.
	Preventive care/ screening/ immunization	No charge	No charge	$70 copay per visit	PAR and Non-PAR provider: not subject to the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	20% coinsurance	40% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	$100 copay per procedure	20% coinsurance	40% coinsurance	Non-PAR provider: 20% penalty without pre-certification

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10 / retail prescription; $20 / mail order prescription	$25 / retail prescription; $50 / mail order prescription	50% coinsurance retail prescriptions	Infertility drugs not covered. Not subject to the "overall" deductible. Subject to formulary guidelines. Plan Provider: Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. PAR Provider: Federally mandated over the counter items are covered with a prescription.
	Brand drugs	$20 / retail prescription; $40 / mail order prescription	$35/retail prescription; $70/mail order prescription	50% coinsurance retail prescriptions	Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible. Subject to formulary guidelines.
	Non-preferred drugs	Not covered	Not covered	50% coinsurance retail prescriptions	Except those prescribed & authorized through the non-preferred drug process (subject to brand copay). Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	20% coinsurance up to $250 per drug dispensed retail and mail order prescriptions	50% coinsurance up to $250 per drug dispensed retail prescriptions	Infertility drugs not covered. PAR and Non-PAR provider: not subject to the "overall" deductible. Subject to formulary guidelines.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay per surgery	20% coinsurance	40% coinsurance	Non-PAR provider: 20% penalty without pre-certification
	Physician/surgeon fees	See Facility fee under "If you have outpatient surgery"	20% coinsurance	40% coinsurance	Non-PAR provider: 20% penalty without pre-certification

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$100 copay each visit	See coverage under plan provider	See coverage under plan provider	Does not include imaging (CT/PET scans, MRIs); Emergency room services and imaging costs waived if admitted as an inpatient.
	Emergency medical transportation	20% coinsurance up to $500 per trip	See coverage under plan provider	See coverage under plan provider	---none---
	Urgent care	$50 copay per visit	$75 copay per visit	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per admission	20% coinsurance	40% coinsurance	Non-PAR provider: 20% penalty without pre-certification
	Physician/surgeon fee	See Facility fee under "If you have a hospital stay"	20% coinsurance	40% coinsurance	Non-PAR provider: 20% penalty without pre-certification
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay each visit	$20 copay per visit (20% coinsurance for covered services received during a visit)	40% coinsurance	PAR provider: copay not subject to the deductible.
	Mental/Behavioral health inpatient services	$500 copay per admission	20% coinsurance	40% coinsurance	Non-PAR provider: 20% penalty without pre-certification
	Substance use disorder outpatient services	$20 copay each visit	$20 copay per visit (20% coinsurance for covered services received during a visit)	40% coinsurance	PAR provider: copay not subject to the deductible.
	Substance use disorder inpatient services	$500 copay per admission	20% coinsurance	40% coinsurance	PAR and Non-PAR provider: limited to acute detoxification. Non-PAR provider: 20% penalty without pre-certification
If you are pregnant	Prenatal and postnatal care	No charge	20% coinsurance	40% coinsurance	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	$500 copay per admission	20% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Participating (PAR) Provider	Your Cost If You Use a Non-Participating (PAR) Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	20% coinsurance	40% coinsurance	Plan provider: limited to less than 8 hours per day and 28 hours per week. PAR and Non-PAR provider: limited to 60 combined visits per calendar year. Non-PAR provider: 20% penalty without pre-certification.
	Rehabilitation services	Outpatient: $20 copay per visit; Inpatient: $500 copay per admission	Outpatient: 20% coinsurance; Inpatient: Not covered	Outpatient: 40% coinsurance; Inpatient: Not covered	Autism spectrum disorders are not subject to the outpatient visit limit. Plan provider: outpatient visits limited to 20 visits per therapy per year; inpatient in a multi-disciplinary facility limited to 60 days per condition per year. PAR and Non-PAR provider: combined outpatient visits limited to 20 visits per therapy per year. Non-PAR provider: 20% penalty without pre-certification.
	Habilitation services	$20 copay per visit	20% coinsurance	40% coinsurance	---none---
	Skilled nursing care	No charge	Not covered	Not covered	Limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered except for the replacement of an arm or leg (20% coinsurance)	Not covered except for the replacement of an arm or leg (20% coinsurance)	Plan provider: limited coverage pursuant to federal and state mandates; prosthetic arms and legs at 20% coinsurance.
	Hospice service	No charge	20% coinsurance	40% coinsurance	---none---
If your child needs dental or eye care	Eye exam	$20 copay per visit	Not covered	Not covered	For services with an ophthalmologist see "Specialist visit"
	Glasses	Not covered	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Glasses	• Long-term care
•	•	• Non-emergency care when traveling outside the U.S.
• Cosmetic surgery	• Hearing aids (Adult)	• Routine foot care
• Dental care (Adult)	•	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Routine eye care (Adult – Plan Provider only)
• Bariatric surgery (Plan provider only)	• Infertility treatment (Plan provider only)	
• Chiropractic care (Plan and PAR provider only)	• Private duty nursing (Plan provider only)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD 711
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 or TTY/TDD 711
CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/711
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5005 or TTY/TDD 711.

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

*The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network portion is underwritten by KPIC, a subsidiary of KFHP.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
- **Plan pays** $6,820
- **Patient pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
- **Plan pays** $4,420
- **Patient pays** $980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$600
Coinsurance	$300
Limits or exclusions	$80
Total	**$980**

Total amounts above are based on plan provider and subscriber only coverage.

*The Kaiser Permanente Point-of-Service Plan is jointly underwritten by Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Permanente Insurance Company (KPIC). The HMO portion is underwritten by KFHP and the PPO and the Out-of-Network Portion is underwritten by KPIC, a subsidiary of KFHP.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC #40264

EXHIBIT A

2017 KAISER PERMANENTE

Denver Fire Department – Active
High Deductible Health Plan $1500

40261 Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** individual (applicable when the coverage is subscriber only)/ **$3,000** family Does not apply to preventive care services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$3,000** individual (applicable when the coverage is subscriber only) / **$6,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 711)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network. S**ee the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 711) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	---none---
	Specialist visit	20% coinsurance	Not covered	---none---
	Other practitioner office visit	Chiropractic care: Not covered; Acupuncture services: Not covered	Not covered	Other practitioners are defined as chiropractic care and acupuncture services.
	Preventive care/ screening / immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$15 / retail prescription; $15 / mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	$40 / retail prescription; $40 / mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	Not covered	Not covered	Except those prescribed and authorized through the non-preferred drug process (subject to the brand copay); infertility drugs not covered.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Subject to formulary guidelines. Infertility drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	---none---
	Physician/surgeon fees	20% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	20% coinsurance	Non-Plan Providers: only covered if you are out of the service area.
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---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	---none---
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder inpatient services	20% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	20% coinsurance	Not covered	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	Outpatient services: 20% coinsurance; Inpatient services: 20% coinsurance.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	20% coinsurance	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice service	20% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	20% coinsurance for routine refractive exams	Not covered	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Long-term care
• Bariatric surgery	• Glasses	• Non-emergency care when traveling outside the U.S.
•	• Hearing aids (Adult)	• Routine foot care
• Cosmetic surgery	• Infertility treatment	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Private duty nursing
•	•	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

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

CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD 711

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
- **Plan pays** $4,620
- **Patient pays** $2,920

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$20
Coinsurance	$1,200
Limits or exclusions	$200
Total	**$2,920**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
- **Plan pays** $3,020
- **Patient pays** $2,380

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,500
Copays	$500
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,380**

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC # 40261

EXHIBIT A

2017 KAISER PERMANENTE

Denver Fire Department – Active
HMO 220 Plan

40259 Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$2,000** individual **/ $4,500** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges, health care this plan doesn't cover; (certain other services may not apply to the out-of-pocket maximum)	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 711)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 per visit	Not covered	---none---
	Specialist visit	$30 per visit	Not covered	---none---
	Other practitioner office visit	Chiropractic care: $20 per visit; Acupuncture services: Not covered	Not covered	Other practitioners are defined as chiropractic care: and acupuncture services; coverage is limited to 20 visits per year for chiropractic care.
	Preventive care/ screening/immunization	No charge	Not covered	---none---
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No charge Lab: No charge	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	$100 per test	Not covered	Multiple cost shares may apply per encounter.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10/retail prescription; $20/mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy. For Southern Colorado members: Prescriptions for second and on-going maintenance medications must be filled at a Pharmacy in a Kaiser Permanente medical office or through Kaiser Permanente mail order.
	Brand drugs	$20 /retail prescription; $40/mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	Not covered	Not covered	Except those prescribed and authorized through the non-preferred drug process (subject to the brand copay); infertility drugs not covered.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Subject to formulary guidelines. Infertility drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 per surgery	Not covered	---none---
	Physician/surgeon fees	Included in facility fee (see facility fee under "If you have outpatient surgery")	Not covered	---none---
If you need immediate medical attention	Emergency room services	$100 per visit	$100 per visit	Does not include imaging (CT/PET scans, MRIs); The "Emergency room services" and "Imaging (CT/PET scans, MRIs)" copayment, if applicable, are waived if you are admitted directly to the hospital as an inpatient.
	Emergency medical transportation	20% coinsurance up to $500 per trip	20% coinsurance up to $500 per trip	---none---
	Urgent care	$50 per visit	$50 per visit	Non-Plan Providers: only covered if you are out of the service area.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 per admission	Not covered	---none---
	Physician/surgeon fee	See Facility fee under "If you have a hospital stay"	Not covered	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 per visit; group visits are 50% of the individual visit	Not covered	---none---
	Mental/Behavioral health inpatient services	$500 per admission	Not covered	---none---
	Substance use disorder outpatient services	$20 per visit; group visits are 50% of the individual visit	Not covered	---none---
	Substance use disorder inpatient services	$500 per admission	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	$500 per admission	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	Outpatient services: $20 copay per visit ; Inpatient services: $500 per admission.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	$20 copay per visit	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	No charge	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice service	No charge	Not covered	---none---
If your child needs dental or eye care	Eye exam	$20 per visit for routine refractive exam	Not covered	For services with an ophthalmologist see "Specialist visit"
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Long-term care
•	• Glasses	• Non-emergency care when traveling outside the U.S.
•	• Hearing aids (Adult)	• Routine foot care
• Cosmetic surgery	•	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	
• Chiropractic care	• Private duty nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD 711
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 or TTY/TDD 711
CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD 711
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5005 or TTY/TDD 711

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

Amount owed to providers: $7,540
- **Plan pays** $6,840
- **Patient pays** $700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$500
Coinsurance	$0
Limits or exclusions	$200
Total	**$700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

Amount owed to providers: $5,400
- **Plan pays** $4,420
- **Patient pays** $980

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$600
Coinsurance	$300
Limits or exclusions	$80
Total	**$980**

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC #40259

EXHIBIT A

2017 KAISER PERMANENTE

Denver Police Department
High Deductible Health Plan 1350

40236 Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,350** individual / **$2,700** family Does not apply to preventive care services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$2,700** individual / **$5,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 711)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network. S**ee the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 711) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	---none---
	Specialist visit	20% coinsurance	Not covered	---none---
	Other practitioner office visit	Chiropractic care: 20% coinsurance; Acupuncture services: Not covered	Not covered	Other practitioners are defined as chiropractic care and acupuncture services. Coverage is limited to 20 visits per year for chiropractic care.
	Preventive care/ screening / immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10 / retail prescription; $20 / mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy.
	Brand drugs	$35 / retail prescription; $70 / mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	$60/retail prescription; $120/mail order prescription	Not covered	Must be authorized through the non-preferred drug process; infertility drugs not covered.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Subject to formulary guidelines. Infertility drugs not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	---none---
	Physician/surgeon fees	20% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	20% coinsurance	Non-Plan Providers: only covered if you are out of the service area.
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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	---none---
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder inpatient services	20% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	Outpatient services: 20% coinsurance; Inpatient services: 20% coinsurance.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	20% coinsurance	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice service	20% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	20% coinsurance for routine refractive exams	Not covered	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Long-term care
• Bariatric surgery	• Glasses	• Non-emergency care when traveling outside the U.S.
•	• Hearing aids (Adult)	• Routine foot care
• Cosmetic surgery	• Infertility treatment	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Private duty nursing
• Chiropractic care	•	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

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

CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD 711

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,720
- **Patient pays** $2,820

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,400
Copays	$20
Coinsurance	$1,200
Limits or exclusions	$200
Total	**$2,820**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,220
- **Patient pays** $2,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,400
Copays	$400
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,180**

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC # 40236

EXHIBIT A

2017 KAISER PERMANENTE

Denver Police Department
Deductible HMO 500 Plan

40235 Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,500** family; Does not apply to preventive care services, certain services with copays and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$3,000** individual / **$6,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges, health care this plan doesn't cover; (certain other services may not apply to the out-of-pocket maximum)	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Specialist visit	$50 copay per visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Other practitioner office visit	Chiropractic care: $30 per visit; Acupuncture services: Not covered	Not covered	Other practitioners are defined as chiropractic care and acupuncture services. Not subject to the overall deductible; does not apply to the out-of-pocket maximum; coverage is limited to 20 visits per year for chiropractic care.
	Preventive care / screening / immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% coinsurance; Lab: No charge	Not covered	Diagnostic lab services: not subject to the overall deductible except when provided in the outpatient department of a hospital; 20% coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$20 / retail prescription; $40 / mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy.
	Brand drugs	$40 / retail prescription; $80 / mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	$60/retail prescription; $120/mail order prescription	Not covered	Not subject to the overall deductible. Must be authorized through the non-preferred drug process; infertility drugs not covered.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	---none---
	Physician/surgeon fees	20% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	$200 per visit	$200 per visit	Does not include imaging (CT/PET Scans, MRIs). Not subject to the overall deductible.
	Emergency medical transportation	20% coinsurance up to $500 per trip	20% coinsurance up to $500 per trip	Not subject to the overall deductible.
	Urgent care	$75 copay per visit (20% coinsurance for covered services received during a visit)	$75 copay per visit (20% coinsurance for covered services received during a visit)	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to the overall deductible.
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---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit; group visits are 50% of the individual visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$30 copay per visit; group visits are 50% of the individual visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Substance use disorder inpatient services	20% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	Outpatient services: $30 copay per visit; Inpatient services: 20% coinsurance	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year. Not subject to the overall deductible.
	Habilitation services	$30 copay per visit	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance
	Hospice service	20% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$30 copay per visit for routine refractive exam (10% coinsurance for covered services received during a visit)	Not covered	For services with an ophthalmologist see "Specialist visit"; Copay not subject to the overall deductible.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture	• Dental care (Adult)	• Long-term care
•	• Glasses	• Non-emergency care when traveling outside the U.S.
•	• Hearing aids (Adult)	• Routine foot care
• Cosmetic surgery	•	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	
• Chiropractic care	• Private-duty nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD 711
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 or TTY/TDD 711
CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD 711
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5005 or TTY/TDD 711

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,100
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,480**

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC # 40235

EXHIBIT A

2017 KAISER PERMANENTE

City and County of Denver Employees
High Deductible Health Plan 1350

40234 Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,350** individual / **$2,700** family Does not apply to preventive care services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$2,700** individual / **$5,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 711)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network. S**ee the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-249-5005 (TTY 711) or visit us at www.kp.org. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-249-5005 (TTY 711) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	Not covered	---none---
	Specialist visit	20% coinsurance	Not covered	---none---
	Other practitioner office visit	Chiropractic care: 20% coinsurance; Acupuncture services: Not covered	Not covered	Other practitioners are defined as chiropractic care and acupuncture services. Coverage is limited to 20 visits per year for chiropractic care.
	Preventive care/ screening / immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not covered	---none---
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---none---
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$10 / retail prescription; $20 / mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy.
	Brand drugs	$35 / retail prescription; $70 / mail order prescription	Not covered	Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	$60/retail prescription; $120/mail order prescription	Not covered	Must be authorized through the non-preferred drug process; infertility drugs not covered.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Subject to formulary guidelines. Infertility drugs not covered.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	---none---
	Physician/surgeon fees	20% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	20% coinsurance	20% coinsurance	Non-Plan Providers: only covered if you are out of the service area.
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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	Not covered	---none---
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder inpatient services	20% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	Outpatient services: 20% coinsurance; Inpatient services: 20% coinsurance.	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year.
	Habilitation services	20% coinsurance	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance.
	Hospice service	20% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	20% coinsurance for routine refractive exams	Not covered	---none---
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Dental care (Adult)	• Long-term care
• Bariatric surgery	• Glasses	• Non-emergency care when traveling outside the U.S.
•	• Hearing aids (Adult)	• Routine foot care
• Cosmetic surgery	• Infertility treatment	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Private duty nursing
• Chiropractic care	•	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

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

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

CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD 711

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

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,720
- **Patient pays** $2,820

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,400
Copays	$20
Coinsurance	$1,200
Limits or exclusions	$200
Total	**$2,820**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,220
- **Patient pays** $2,180

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,400
Copays	$400
Coinsurance	$300
Limits or exclusions	$80
Total	**$2,180**

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC # 40234

EXHIBIT A

2017 KAISER PERMANENTE

City and County of Denver Employees
Deductible HMO Plan 500

40233 Summary of Benefits Coverage

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.kp.org/plandocuments or by calling 1-855-249-5005 or TTY 711.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,500** family; Does not apply to preventive care services, certain services with copays and prescription drugs.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.**
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes, **$3,000** individual / **$6,000** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balanced-billed charges, health care this plan doesn't cover; (certain other services may not apply to the out-of-pocket maximum)	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes, see **www.kp.org or call 1-855-249-5005 (TTY 1-800-521-4874)** for a list of plan **providers**.	If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers.**
Do I need a referral to see a specialist?	No	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use plan **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Specialist visit	$50 copay per visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Other practitioner office visit	Chiropractic care: $30 per visit; Acupuncture services: Not covered	Not covered	Other practitioners are defined as chiropractic care and acupuncture services. Not subject to the overall deductible; does not apply to the out-of-pocket maximum; coverage is limited to 20 visits per year for chiropractic care.
	Preventive care / screening / immunization	No charge	Not covered	Not subject to the overall deductible.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: 20% coinsurance; Lab: No charge	Not covered	Diagnostic lab services: not subject to the overall deductible except when provided in the outpatient department of a hospital; 20% coinsurance in the outpatient department of a hospital.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary	Generic drugs	$20 / retail prescription; $40 / mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered. Federally mandated over the counter items are covered with a prescription when filled at a Kaiser Permanente pharmacy.
	Brand drugs	$40 / retail prescription; $80 / mail order prescription	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered.
	Non-preferred drugs	$60/retail prescription; $120/mail order prescription	Not covered	Not subject to the overall deductible. Must be authorized through the non-preferred drug process; infertility drugs not covered.
	Specialty drugs	Cost share for generic, brand or non-preferred drugs may apply	Not covered	Not subject to the overall deductible. Subject to formulary guidelines. Infertility drugs not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	---none---
	Physician/surgeon fees	20% coinsurance	Not covered	---none---
If you need immediate medical attention	Emergency room services	$200 per visit	$200 per visit	Does not include imaging (CT/PET Scans, MRIs). Not subject to the overall deductible.
	Emergency medical transportation	20% coinsurance up to $500 per trip	20% coinsurance up to $500 per trip	Not subject to the overall deductible.
	Urgent care	$75 copay per visit (20% coinsurance for covered services received during a visit)	$75 copay per visit (20% coinsurance for covered services received during a visit)	Non-Plan Providers: only covered if you are out of the service area. Copay not subject to the overall deductible.
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---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay per visit; group visits are 50% of the individual visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	---none---
	Substance use disorder outpatient services	$30 copay per visit; group visits are 50% of the individual visit (20% coinsurance for covered services received during a visit)	Not covered	Copay not subject to the overall deductible.
	Substance use disorder inpatient services	20% coinsurance	Not covered	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	Not covered	After confirmation of pregnancy, for the normal series of regularly scheduled routine visits.
	Delivery and all inpatient services	20% coinsurance	Not covered	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Plan Provider	Your Cost If You Use a Non-Plan Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Coverage is limited to less than 8 hours per day and 28 hours per week
	Rehabilitation services	Outpatient services: $30 copay per visit; Inpatient services: 20% coinsurance	Not covered	Outpatient visits limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit); Inpatient in a multi-disciplinary facility limited to 60 days per condition per year. Not subject to the overall deductible.
	Habilitation services	$30 copay per visit	Not covered	Limited to 20 visits per therapy per year (autism spectrum disorders are not subject to the visit limit).
	Skilled nursing care	20% coinsurance	Not covered	Coverage is limited to 100 days per year
	Durable medical equipment	20% coinsurance	Not covered	Coverage is limited to items on our DME formulary. Prosthetic arms and legs not to exceed 20% coinsurance
	Hospice service	20% coinsurance	Not covered	---none---
If your child needs dental or eye care	Eye exam	$30 copay per visit for routine refractive exam (10% coinsurance for covered services received during a visit)	Not covered	For services with an ophthalmologist see "Specialist visit"; Copay not subject to the overall deductible.
	Glasses	Not covered	Not covered	---none---
	Dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

• Acupuncture	• Dental care (Adult)	• Long-term care
•	• Glasses	• Non-emergency care when traveling outside the U.S.
•	• Hearing aids (Adult)	• Routine foot care
• Cosmetic surgery	•	• Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
•	• Hearing aids (Children under the age of 18)	• Routine eye care (Adult)
• Bariatric surgery	• Infertility treatment	
• Chiropractic care	• Private-duty nursing	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-249-5005 or TTY 711. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: The plan at 1-855-249-5005 or TTY 711; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; or the Colorado Division of Insurance, Consumer Affairs Section, at 1560 Broadway, Ste 850, Denver, CO 80202 or call: 303-894-7490 (in-state, toll-free: 800-930-3745), or email: insurance@dora.state.co.us.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-855-249-5005 or TTY/TDD 711
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-249-5005 or TTY/TDD 711
CHINESE: 若有問題：請撥打1-855-249-5005 或 TTY/TDD 711
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-249-5005 or TTY/TDD 711

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,520
- **Patient pays** $2,020

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$500
Copays	$20
Coinsurance	$1,300
Limits or exclusions	$200
Total	**$2,020**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,920
- **Patient pays** $1,480

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$1,100
Coinsurance	$300
Limits or exclusions	$80
Total	**$1,480**

Total amounts above are based on subscriber only coverage.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

SBC # 40233

EXHIBIT A

2017 KAISER PERMANENTE

UNDERWRITING ASSUMPTIONS

Rate Assumptions and Requirements

Group Name: CITY AND COUNTY OF DENVER

Group Numbers: 75

Subgroups: 013,014,015,023,024,025,033, 034,035,039,043,044,045,050

Region: Colorado

Contract Period: 01/01/2017 - 12/31/2017

KP Offered: Alongside other carrier(s)

Quotes Included

2017 CCD DHMO Plan - 15902281
2017 CCD HDHP Plan - 15902284

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. **Group-specific requirements:**
   None

2. **Rating Assumptions:**
   Rates assume a 12-month policy period of 1/1/2017 through 12/31/2017 unless otherwise specified above.
   The rates and benefits in this proposal include the Federal Health Care Reform requirements. If the insured employer makes changes in excess to those allowed under the interim final guidance in the Patient Protection and Affordable Care Act (PPACA), the plan would not be grandfathered and would have all applicable PPACA mandates applied. For confirmation of the status of your plan, please contact your Kaiser Permanente account manager. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.
   KP reserves the right to rerate if actual enrollment results in a +/-10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:
   a. A change in the demographic factor.
   b. A change in the average family size or subscriber distribution.
   c. A change in the number of subscribers enrolled in KP.
   d. A change in the number of plans offered alongside KP.
   e. A change in the benefit design of a plan offered alongside KP.
   f. A change in the employer contribution formula.
   g. Groups must abide by the Break-in and Break-away Policy.

   KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. **Participation and contribution requirements:**
   a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
   b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. **Quote assumes KP is offered alongside another health care plan**
   KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:
   a. KP is offered to all eligible employees.
   b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.

c. The employer's contribution formula does not put KP in a disadvantaged position. This quote assumes that all benefit plans offered to group subscribers provide similar benefits and levels of coverage. If not, the employer's contribution strategy must account for benefit differences among plans offered to subscribers. For example, if KP provides coverage in excess of the minimum essential level of coverage required by law, and another plan does not, the employer will ensure that the member contribution for KP's plan does not exceed the dollar amount for the other plan.
d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.
h. No other plan is allowed preferential treatment that adversely affects KP.
i. KP prefers that the number of employee subscribers enrolled in KP be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. Product-specific participation requirements:

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. Please refer to the group's contract for full definitions of Primary Medicare and Secondary Medicare.
b. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. In some regions members with only Part B may also enroll but their rates will be subject to a surcharge.
c. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
d. Enrollment in Medicare Senior Advantage (KPSA), Medicare Plus and Medicare Cost is contingent upon receipt of an accurately completed enrollment form.
e. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
f. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. Proposal requires eligibility for KP plan based on the following:

a. Employer - the employer cannot be considered a small group according to state law.
b. Actives:
- The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
- An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and works the minimum number of hours mandated by federal and/or state law to be considered an "eligible employee." Any agreement to change the minimum hours required must be in writing. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
- The employee must live only in the service area specific to the product they enroll in.
- 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.

c. New enrollees:
The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.

d. COBRA

- It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
- It is the employer's responsibility to comply with appropriate COBRA statutes.
- KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.

e. Retirees

- Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
- Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
- Medicare eligible retirees cannot enroll in the active plan.
- Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.

f. Dependents

- If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. Compliance:

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

8. Broker Payment:

Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Annual Trend	The projected annual percent change in medical and pharmacy expenses applied to a group's claims experience.
Area Factor	A factor that adjusts the manual rate to reflect geographic price differentials.
Average Members	The average monthly membership during the reporting period.
Benefit Adjusted Manual Rate	The average rate for a group's current benefit plan for a particular market segment.
Capping	A method of stabilizing year-to-year rate changes.
COBRA Factor	An adjustment made to the manual rate to reflect the proportion of COBRA enrollees.
Contract Period	The time period during which a rate is valid.
Credibility	The weighting applied to manual, risk or claims-based rates when developing required premium rates.
Demographic Change	An adjustment made in the Projected Claims Calculation to reflect changes in the group demographics that occurred between the experience period and the time of the quote.
Demographic Factor	An adjustment made to the manual rate to reflect a group's current demographics.
Federal Health Insurer Fee	A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.
Federal PCORI Fee	A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution	A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.
Formulary	A list of preferred drugs based on their effectiveness and value.
Future Benefit Change	An adjustment to the rate to reflect a change in benefits being quoted for the renewal period.
Historical Benefit Change	An adjustment made to historical paid claims to reflect the group's current benefit level.
Incurred Claim Adjustment	An adjustment made to a group's paid claims to convert them to estimated incurred claims.
In-force PMPM Rate	A group's current monthly PMPM (per member per month) rate.
Integrated Care Management (ICM) Fee	This charge, which is currently included in Paid Claims, incorporates services such as chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services that are not billed or can't be done so efficiently. At KP, integrated care management cannot be unbundled, as it is part of the unique care and services the Permanente Medical Groups deliver to get and keep our members healthy.
Kaiser Permanente Senior Advantage (KPSA)	Kaiser Permanente's Medicare Advantage plan, offered in all regions except Mid-Atlantic, which offers Medicare Plus (Cost) instead.
Kaiser Permanente Medicare Plus (Cost)	Kaiser Permanente's Medicare Cost plan, offered in Mid-Atlantic only. No Medicare Advantage plan is offered in this region.
Late Payment Charge	A fee added to the rate to compensate KP for a groupâ€™s late payment history.
Market Segment	Group divisions based on group size and/or line of business such as Labor Trust or National Accounts.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Other Benefits	Benefits that are not included in the manual rate nor in the paid claims.
Other Medical Services (OMS)	Other Medical Services (OMS) is a component of claims that accounts for services that are not easily captured in our claims and encounter systems. OMS includes but is not limited to capitated services, incomplete coding of KP services, COB and third-party liability.
Paid Claims	Paid medical expenses for services provided to a health plan member. These are either the result of an internal service, where prices are based on a fee schedule, or an external claim for services from a non-KP provider. Claims are attributed to the month in which they were paid (external) or reported (internal).
Pooling Charge	The per member per month charge included in the Projected Claims Calculation to compensate for the removal of claims exceeding the pooling point.
Pooling Credit	The total combined medical and prescription drug claims paid above the pooling point. This amount is removed from paid claims in the Projected Claims Calculation.
Pooling Point	The annual threshold above which a member's combined medical and prescription drug claims will be excluded from the group's rate calculation.
Quoted Rate	The renewal rate calculated on a per member per month basis.
Rate Assumptions and Requirements	A component of the customer renewal report package that documents terms and conditions of the rate proposal.
Rating Members	The membership during the rating month used in the renewal.
Rating Month	The month of the membership and benefits used to calculate the renewal.
Report Period	The period of time over which prior claims are aggregated and used to project future claim costs.
Reporting Threshold	Used on the High Cost Claimants report, it is the minimum in total claims in the reporting period required for a member to be displayed. The threshold varies by group size.
Retention	The portion of premium retained by KP to cover Health Plan administration expenses such as billing, member services and marketing.
Risk Factor	A comparison of a group's projected medical expenses to the average based on the group members' demographics and experience period prescription drug use.
Trend Factor	A factor that projects historical claims to a future rating period.
Underwriter Adjustment	An adjustment to the rate made by the underwriter to reflect differences in risk or offering conditions not accounted for elsewhere in the rate development.
Work Status Factor	An adjustment made to the manual rate to reflect the under 65 retiree population's influence on projected medical expenses.

Rate Assumptions and Requirements

Group Name: Denver Fire Department

Group Numbers: 74

Subgroups: 001,002,003,005,007,012,013, 014,016,019,025,026,027,028

Region: Colorado

Contract Period: 01/01/2017 - 12/31/2017

KP Offered: Alongside other carrier(s)

Quotes Included

2017 Denver Fire HDHP Retirees - 16016272
2017 Denver Fire HDHP Actives - 16016287
2017 Denver Fire HMO Actives - 16016282
2017 Denver Fire HMO Retirees - 16016274
2017 Denver Fire POS Actives - 16016273
2017 Denver Fire POS Retirees - 16016276
2017 Denver Fire PPO - 16016280

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. **Group-specific requirements:**
   None

2. **Rating Assumptions:**
   Rates assume a 12-month policy period of 1/1/2017 through 12/31/2017 unless otherwise specified above.
   The rates and benefits in this proposal include the Federal Health Care Reform requirements. If the insured employer makes changes in excess to those allowed under the interim final guidance in the Patient Protection and Affordable Care Act (PPACA), the plan would not be grandfathered and would have all applicable PPACA mandates applied. For confirmation of the status of your plan, please contact your Kaiser Permanente account manager. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.
   KP reserves the right to rerate if actual enrollment results in a +/-10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:
   a. A change in the demographic factor.
   b. A change in the average family size or subscriber distribution.
   c. A change in the number of subscribers enrolled in KP.
   d. A change in the number of plans offered alongside KP.
   e. A change in the benefit design of a plan offered alongside KP.
   f. A change in the employer contribution formula.
   g. Groups must abide by the Break-in and Break-away Policy.

   KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. **Participation and contribution requirements:**
   a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
   b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

Rate Assumptions and Requirements

Group Name: Denver Fire Department

Group Numbers: 74

Subgroups: 001,002,003,005,007,012,013, 014,016,019,025,026,027,028

Region: Colorado

Contract Period: 01/01/2017 - 12/31/2017

KP Offered: Alongside other carrier(s)

4. Quote assumes KP is offered alongside another health care plan

KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:

a. KP is offered to all eligible employees.
b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.
c. The employer's contribution formula does not put KP in a disadvantaged position. This quote assumes that all benefit plans offered to group subscribers provide similar benefits and levels of coverage. If not, the employer's contribution strategy must account for benefit differences among plans offered to subscribers. For example, if KP provides coverage in excess of the minimum essential level of coverage required by law, and another plan does not, the employer will ensure that the member contribution for KP's plan does not exceed the dollar amount for the other plan.
d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.
h. No other plan is allowed preferential treatment that adversely affects KP.
i. KP prefers that the number of employee subscribers enrolled in KP be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. Product-specific participation requirements:

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. Please refer to the group's contract for full definitions of Primary Medicare and Secondary Medicare.
b. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. In some regions members with only Part B may also enroll but their rates will be subject to a surcharge.
c. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
d. Enrollment in Medicare Senior Advantage (KPSA), Medicare Plus and Medicare Cost is contingent upon receipt of an accurately completed enrollment form.
e. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
f. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. Proposal requires eligibility for KP plan based on the following:

a. Employer - the employer cannot be considered a small group according to state law.
b. Actives:
   - The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
   - An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and works the minimum number of hours mandated by federal and/or state law to be considered an "eligible employee." Any agreement to change the minimum hours required must be in writing. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
   - The employee must live only in the service area specific to the product they enroll in.
   - 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.

c. New enrollees:
The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.

d. COBRA
- It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
- It is the employer's responsibility to comply with appropriate COBRA statutes.
- KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.

e. Retirees
- Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
- Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
- Medicare eligible retirees cannot enroll in the active plan.
- Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.

f. Dependents
- If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. Compliance:
KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

8. Broker Payment:
Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Annual Trend	The projected annual percent change in medical and pharmacy expenses applied to a group's claims experience.
Area Factor	A factor that adjusts the manual rate to reflect geographic price differentials.
Average Members	The average monthly membership during the reporting period.
Benefit Adjusted Manual Rate	The average rate for a group's current benefit plan for a particular market segment.
Capping	A method of stabilizing year-to-year rate changes.
COBRA Factor	An adjustment made to the manual rate to reflect the proportion of COBRA enrollees.
Contract Period	The time period during which a rate is valid.
Credibility	The weighting applied to manual, risk or claims-based rates when developing required premium rates.
Demographic Change	An adjustment made in the Projected Claims Calculation to reflect changes in the group demographics that occurred between the experience period and the time of the quote.
Demographic Factor	An adjustment made to the manual rate to reflect a group's current demographics.
Federal Health Insurer Fee	A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.
Federal PCORI Fee	A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution	A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.
Formulary	A list of preferred drugs based on their effectiveness and value.
Future Benefit Change	An adjustment to the rate to reflect a change in benefits being quoted for the renewal period.
Historical Benefit Change	An adjustment made to historical paid claims to reflect the group's current benefit level.
Incurred Claim Adjustment	An adjustment made to a group's paid claims to convert them to estimated incurred claims.
In-force PMPM Rate	A group's current monthly PMPM (per member per month) rate.
Integrated Care Management (ICM) Fee	This charge, which is currently included in Paid Claims, incorporates services such as chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services that are not billed or can't be done so efficiently. At KP, integrated care management cannot be unbundled, as it is part of the unique care and services the Permanente Medical Groups deliver to get and keep our members healthy.
Kaiser Permanente Senior Advantage (KPSA)	Kaiser Permanente's Medicare Advantage plan, offered in all regions except Mid-Atlantic, which offers Medicare Plus (Cost) instead.
Kaiser Permanente Medicare Plus (Cost)	Kaiser Permanente's Medicare Cost plan, offered in Mid-Atlantic only. No Medicare Advantage plan is offered in this region.
Late Payment Charge	A fee added to the rate to compensate KP for a groupâ€™s late payment history.
Market Segment	Group divisions based on group size and/or line of business such as Labor Trust or National Accounts.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Other Benefits	Benefits that are not included in the manual rate nor in the paid claims.
Other Medical Services (OMS)	Other Medical Services (OMS) is a component of claims that accounts for services that are not easily captured in our claims and encounter systems. OMS includes but is not limited to capitated services, incomplete coding of KP services, COB and third-party liability.
Paid Claims	Paid medical expenses for services provided to a health plan member. These are either the result of an internal service, where prices are based on a fee schedule, or an external claim for services from a non-KP provider. Claims are attributed to the month in which they were paid (external) or reported (internal).
Pooling Charge	The per member per month charge included in the Projected Claims Calculation to compensate for the removal of claims exceeding the pooling point.
Pooling Credit	The total combined medical and prescription drug claims paid above the pooling point. This amount is removed from paid claims in the Projected Claims Calculation.
Pooling Point	The annual threshold above which a member's combined medical and prescription drug claims will be excluded from the group's rate calculation.
Quoted Rate	The renewal rate calculated on a per member per month basis.
Rate Assumptions and Requirements	A component of the customer renewal report package that documents terms and conditions of the rate proposal.
Rating Members	The membership during the rating month used in the renewal.
Rating Month	The month of the membership and benefits used to calculate the renewal.
Report Period	The period of time over which prior claims are aggregated and used to project future claim costs.
Reporting Threshold	Used on the High Cost Claimants report, it is the minimum in total claims in the reporting period required for a member to be displayed. The threshold varies by group size.
Retention	The portion of premium retained by KP to cover Health Plan administration expenses such as billing, member services and marketing.
Risk Factor	A comparison of a group's projected medical expenses to the average based on the group members' demographics and experience period prescription drug use.
Trend Factor	A factor that projects historical claims to a future rating period.
Underwriter Adjustment	An adjustment to the rate made by the underwriter to reflect differences in risk or offering conditions not accounted for elsewhere in the rate development.
Work Status Factor	An adjustment made to the manual rate to reflect the under 65 retiree population's influence on projected medical expenses.

Rate Assumptions and Requirements

Group Name: DENVER POLICE DEPARTMENT

Group Numbers: 68

Subgroups: 030,031,032,033,034,035,036, 037,038,039,040,041,042,043

Region: Colorado

Contract Period: 01/01/2017 - 12/31/2017

KP Offered: Alongside other carrier(s)

Quotes Included

2017 DP DHMO Plan - 15902272
2017 DP HDHP Plan - 15902275

Proposal Assumptions

The proposed rates and benefits included on the Rate and Benefit Summary page are based on the **participation and contribution requirements** described below. If any of the following are not met, Kaiser Permanente (KP) reserves the right to withdraw our rate proposal, decline coverage, re-rate this proposal or terminate your Group Agreement.

1. **Group-specific requirements:**
   None

2. **Rating Assumptions:**
   Rates assume a 12-month policy period of 1/1/2017 through 12/31/2017 unless otherwise specified above.
   The rates and benefits in this proposal include the Federal Health Care Reform requirements. If the insured employer makes changes in excess to those allowed under the interim final guidance in the Patient Protection and Affordable Care Act (PPACA), the plan would not be grandfathered and would have all applicable PPACA mandates applied. For confirmation of the status of your plan, please contact your Kaiser Permanente account manager. KP reserves the right to modify the rates and benefits if we receive further clarification of Federal Health Care Reform requirements, or to incorporate other applicable Federal Health Care Reform requirements. In addition, Kaiser Permanente reserves the right to make any change in these rates and benefits due to changes in State or Federal legislation or regulatory action.
   KP reserves the right to rerate if actual enrollment results in a +/-10% change in the rates from what was assumed at the time of this quote. Examples of changes that may impact rates include, but are not limited to, the following:
   a. A change in the demographic factor.
   b. A change in the average family size or subscriber distribution.
   c. A change in the number of subscribers enrolled in KP.
   d. A change in the number of plans offered alongside KP.
   e. A change in the benefit design of a plan offered alongside KP.
   f. A change in the employer contribution formula.
   g. Groups must abide by the Break-in and Break-away Policy.

   KP reserves the right to change the rates in the event the employer funds, or offers to fund, all or part of an individual or family deductible, copayment or coinsurance which is applicable under the KP plan unless specifically noted in the Group-Specific Requirements above.

3. **Participation and contribution requirements:**
   a. Proposed rates and benefits assume 75% of overall eligible group employees enroll in a company-sponsored plan excluding those waiving for alternative group coverage.
   b. Proposal assumes employer pays at least 50% of the employee only cost and is non-discriminatory.

4. **Quote assumes KP is offered alongside another health care plan**
   KP must be offered on conditions that are no less favorable than those for other health care plans. Examples include, but are not limited to, the following:
   a. KP is offered to all eligible employees.
   b. KP has access to the employer and to the employees on the same basis as all other health care plans offered.

c. The employer's contribution formula does not put KP in a disadvantaged position. This quote assumes that all benefit plans offered to group subscribers provide similar benefits and levels of coverage. If not, the employer's contribution strategy must account for benefit differences among plans offered to subscribers. For example, if KP provides coverage in excess of the minimum essential level of coverage required by law, and another plan does not, the employer will ensure that the member contribution for KP's plan does not exceed the dollar amount for the other plan.
d. Basic and optional benefits such as DME, prescription drugs, and infertility are comparable among all health care plans offered, however, KP will allow preventive services as defined by Health and Human Services (HHS) to vary if specifically approved by underwriting.
e. KP is not offered alongside plans with pre-existing condition provisions, health condition exceptions or lifetime coverage limits.
f. If early retirees are covered, the employer offers all health care plans to early retirees on the same basis.
g. Eligibility rules such as dependent age limits and waiting periods for new hires are the same for all health care plans.
h. No other plan is allowed preferential treatment that adversely affects KP.
i. KP prefers that the number of employee subscribers enrolled in KP be the greater of 5 or 5% of the total number of employees enrolled in all health plans in regions where KP is offered.
j. Kaiser Permanente must NOT be offered along side an age-rated health care plan.
k. Rate tier ratios and their definitions should be the same among all health plans offered by the group (employer).

5. Product-specific participation requirements:

Additional Kaiser Permanente Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost Requirements:

a. Please refer to the group's contract for full definitions of Primary Medicare and Secondary Medicare.
b. Members must have Medicare Parts A and B to enroll in Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost and be eligible for Medicare rates. In some regions members with only Part B may also enroll but their rates will be subject to a surcharge.
c. Medicare eligible members must reside in the approved Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost service areas to receive benefits for the group Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost offering.
d. Enrollment in Medicare Senior Advantage (KPSA), Medicare Plus and Medicare Cost is contingent upon receipt of an accurately completed enrollment form.
e. Preliminary Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost rates and benefits are subject to change.
f. Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost products may not be available for sale in all KP regions.

Additional Out-of-Area Product Requirements:

a. All employees offered KP Out-of-Area products must reside and work outside the KP service area.

6. Proposal requires eligibility for KP plan based on the following:

a. Employer - the employer cannot be considered a small group according to state law.
b. Actives:
- The group (employer) must be related to those offered a KP plan by virtue of employment. This includes when the group contract is with a Taft-Hartley Trust, Professional Employer Organization (PEO), association or Joint Power of Authority (JPA).
- An eligible employee is defined as an active, permanent employee who is on the employer's payroll, and works the minimum number of hours mandated by federal and/or state law to be considered an "eligible employee." Any agreement to change the minimum hours required must be in writing. Temporary and independent contractors (i.e., 1099 employees) are not eligible unless noted otherwise in this Rate Assumptions and Requirements document.
- The employee must live only in the service area specific to the product they enroll in.
- 100% of eligible employees must be covered by Worker's Compensation, where mandated by law.

c. New enrollees:
The probationary period for new employees is non-discriminatory and reflects no more than a 90-day waiting period unless noted otherwise in this Rate Assumptions and Requirements document.

d. COBRA

- It is the responsibility of the employer group to enroll eligible members into the KP COBRA plan in compliance with federal law.
- It is the employer's responsibility to comply with appropriate COBRA statutes.
- KP will generally include COBRA members as part of the group bill. If individual billing has been arranged, KP will assume responsibility for collecting premiums from COBRA members, only acting as a collection agent on behalf of the group, not as a fiduciary for the group. In addition, KP retains the authority to terminate a direct-billed member for non-payment.

e. Retirees

- Eligible early retirees must enroll in a health plan at the time of retirement and may later elect to enroll in a KP plan at open enrollment as long as they have maintained continuous enrollment in a health plan since the time of retirement.
- Early retirees under the age of 65 must be reported to KP and set up as a separate employee class or subgroup.
- Medicare eligible retirees cannot enroll in the active plan.
- Applicants for a Medicare Senior Advantage (KPSA), Medicare Plus or Medicare Cost plan must meet all the Medicare eligibility requirements, including those stated in this Rate Assumptions and Requirements document.

f. Dependents

- If an "in-area" employee has dependents that live outside the service area, the employee and dependents must be enrolled in the same product.

7. Compliance:

KP reserves the right to make any change in the employer group's benefits and/or rates due to changes in State or Federal legislation or regulatory action.

8. Broker Payment:

Brokers may be paid commissions and other financial incentives by Kaiser Permanente.

The contracting employer must also meet all other group-specific responsibilities and requirements described in your Group Agreement.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Annual Trend	The projected annual percent change in medical and pharmacy expenses applied to a group's claims experience.
Area Factor	A factor that adjusts the manual rate to reflect geographic price differentials.
Average Members	The average monthly membership during the reporting period.
Benefit Adjusted Manual Rate	The average rate for a group's current benefit plan for a particular market segment.
Capping	A method of stabilizing year-to-year rate changes.
COBRA Factor	An adjustment made to the manual rate to reflect the proportion of COBRA enrollees.
Contract Period	The time period during which a rate is valid.
Credibility	The weighting applied to manual, risk or claims-based rates when developing required premium rates.
Demographic Change	An adjustment made in the Projected Claims Calculation to reflect changes in the group demographics that occurred between the experience period and the time of the quote.
Demographic Factor	An adjustment made to the manual rate to reflect a group's current demographics.
Federal Health Insurer Fee	A percent of premium fee paid by insurance carriers for commercial and Medicare business beginning January 1, 2014.
Federal PCORI Fee	A fee per covered life paid by commercial insurers and self-funded plan sponsors to fund the Patient-Centered Outcomes Research Institute (PCORI). PCORI was established by the Affordable Care Act. The PCORI will commission studies that compare drugs, medical devices, tests, surgeries and ways to deliver health care.
Federal Transitional Reinsurance Program Contribution	A fee paid by commercial insurers and third party administrators for self-funded plans from 2014 through 2016 to support reinsurance to individual market insurers covering high risk individuals in Exchanges.
Formulary	A list of preferred drugs based on their effectiveness and value.
Future Benefit Change	An adjustment to the rate to reflect a change in benefits being quoted for the renewal period.
Historical Benefit Change	An adjustment made to historical paid claims to reflect the group's current benefit level.
Incurred Claim Adjustment	An adjustment made to a group's paid claims to convert them to estimated incurred claims.
In-force PMPM Rate	A group's current monthly PMPM (per member per month) rate.
Integrated Care Management (ICM) Fee	This charge, which is currently included in Paid Claims, incorporates services such as chronic conditions management, pharmacy management, clinical access alternatives, telephonic clinical advice, wellness information and coaching, online personal health management, medical and case management, external provider network management, and other care management services that are not billed or can't be done so efficiently. At KP, integrated care management cannot be unbundled, as it is part of the unique care and services the Permanente Medical Groups deliver to get and keep our members healthy.
Kaiser Permanente Senior Advantage (KPSA)	Kaiser Permanente's Medicare Advantage plan, offered in all regions except Mid-Atlantic, which offers Medicare Plus (Cost) instead.
Kaiser Permanente Medicare Plus (Cost)	Kaiser Permanente's Medicare Cost plan, offered in Mid-Atlantic only. No Medicare Advantage plan is offered in this region.
Late Payment Charge	A fee added to the rate to compensate KP for a groupâ€™s late payment history.
Market Segment	Group divisions based on group size and/or line of business such as Labor Trust or National Accounts.

Glossary of Terms

Term	Kaiser Foundation Health Plan
Other Benefits	Benefits that are not included in the manual rate nor in the paid claims.
Other Medical Services (OMS)	Other Medical Services (OMS) is a component of claims that accounts for services that are not easily captured in our claims and encounter systems. OMS includes but is not limited to capitated services, incomplete coding of KP services, COB and third-party liability.
Paid Claims	Paid medical expenses for services provided to a health plan member. These are either the result of an internal service, where prices are based on a fee schedule, or an external claim for services from a non-KP provider. Claims are attributed to the month in which they were paid (external) or reported (internal).
Pooling Charge	The per member per month charge included in the Projected Claims Calculation to compensate for the removal of claims exceeding the pooling point.
Pooling Credit	The total combined medical and prescription drug claims paid above the pooling point. This amount is removed from paid claims in the Projected Claims Calculation.
Pooling Point	The annual threshold above which a member's combined medical and prescription drug claims will be excluded from the group's rate calculation.
Quoted Rate	The renewal rate calculated on a per member per month basis.
Rate Assumptions and Requirements	A component of the customer renewal report package that documents terms and conditions of the rate proposal.
Rating Members	The membership during the rating month used in the renewal.
Rating Month	The month of the membership and benefits used to calculate the renewal.
Report Period	The period of time over which prior claims are aggregated and used to project future claim costs.
Reporting Threshold	Used on the High Cost Claimants report, it is the minimum in total claims in the reporting period required for a member to be displayed. The threshold varies by group size.
Retention	The portion of premium retained by KP to cover Health Plan administration expenses such as billing, member services and marketing.
Risk Factor	A comparison of a group's projected medical expenses to the average based on the group members' demographics and experience period prescription drug use.
Trend Factor	A factor that projects historical claims to a future rating period.
Underwriter Adjustment	An adjustment to the rate made by the underwriter to reflect differences in risk or offering conditions not accounted for elsewhere in the rate development.
Work Status Factor	An adjustment made to the manual rate to reflect the under 65 retiree population's influence on projected medical expenses.

EXHIBIT A

2017 KAISER PERMANENTE

PERFORMANCE GUARANTEES

KAISER PERMANENTE®

Kaiser Permanente Colorado
2016 Performance Guarantees Agreement
City and County of Denver

Guaranteed Performance
We are pleased to offer a performance guarantee backed by a percentage of your annual non-Medicare premium if you have an average of 500 or more non-Medicare members in Kaiser Permanente Colorado in 2016. (In 2017, we will conduct a review of your 2016 monthly membership to determine the annual average.)

Changes in Measures
Some of our performance measures use definitions determined by national organizations such as the National Committee for Quality Assurance (NCQA.) If the definition for such a measure changes after these guarantees have been implemented we can no longer guarantee the measure. This includes any changes by NCQA in reporting rules or decisions by NCQA regarding publication of the Quality Compass. We do not accept conversions or substitutions of HEDIS measures. Should any guaranteed HEDIS measure be rotated for calendar year 2016 it will be ignored for purposes of performance evaluation and penalty calculation.

If we are unable to provide any of the information guaranteed in this agreement due to federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties.

Setting Penalty Thresholds
To the extent possible, we set our penalty thresholds (i.e., the performance level we guarantee and below which we pay 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.

Reporting Frequency and Guarantee Duration
Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year and a semi-annual performance report for the current year. Performance guarantees require annual renewal and must be requested each year by the purchaser.

Penalty Payments
We report performance results based on our annual (calendar year) performance. Penalty payments are determined after the end of the year and are based on your total non-Medicare premium for the calendar year. We pay agreed-upon penalties by check.

Forfeiture on sample-based measures is contingent on statistically meaningful variations from penalty thresholds. A standard statistical test is used to determine whether results are above or below the applicable state/regional or national average. If the test shows that the differences in the results are too large to be explained by random chance, but are true differences at least 95% of the time, the results are considered statistically different from the penalty threshold.

Issues leading to failure on measures of satisfaction with account management are defined as those related to the administration of the plan that are under direct control of the account management team (e.g. account management adequately answers customer questions, keeps customer informed of new developments, strives to resolve administrative problems.) Issues related to other health plan areas (e.g. pricing, member call centers, 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 purchaser 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 us the opportunity to provide health care services to your employees and their families. Please contact your Account Manager if you have questions or comments concerning this agreement.

KAISER PERMANENTE®

Kaiser Permanente Colorado
2016 Performance Guarantees Agreement
City and County of Denver

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

	2016 Performance Measures	Penalty Threshold	Penalty (% of Premium)
Implementation, Administration and Account Management			
1.	Eligibility information accessible to medical groups within eight business days	95%	0.11%
2.	Premium/Eligibility reconciliation within 30 calendar days (% of purchasers)[1]	85%	0.11%
3.	ID card processing within10 business days	93%	0.11%
4.	Purchaser satisfaction with account management	Purchaser satisfied; see provisions on cover page	0.12%
Member Services			
5.	Member Services calls answered within 30 seconds	80%	0.10%
6.	Telephone call abandonment rate	≤ 3.0%	0.10%
Member Satisfaction and Access			
7.	Overall member satisfaction with health plan (CAHPS 4.0 #42; % 8-10)	≥ CO HMO Avg.*	0.12%
8.	Member satisfaction with customer service (CAHPS 4.0 composite #s 35, 36; (% 'usually or always')	≥ CO HMO Avg.*	0.12%
9.	Member rating of personal doctor (CAHPS 4.0 #21; 8-10)	≥ CO HMO Avg.*	0.12%
10.	Kp.org web site availability (for non-secure sections, and excluding scheduled maintenance)	98.5%	0.12%
Quality (HEDIS Effectiveness of Care)			
11.	Diabetes – Controlling High Blood Pressure	≥ Natl. HMO Avg. *	0.12%
12.	Colorectal Cancer Screening Rate	≥ Natl. HMO Avg. *	0.10%
13.	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. HMO Avg. *	0.10%
14.	Use of Appropriate Medications for Asthma	≥ Natl. HMO Avg. *	0.11%
15.	Persistence of Beta Blocker Treatment after Heart Attack	≥ Natl. HMO Avg. *	0.11%
16.	Appropriate Treatment for Children with Upper Respiratory Infection	≥ Natl. HMO Avg. *	0.11%
17.	Antidepressant Medication Management (Acute)	≥ Natl. HMO Avg. *	0.11%
18.	Mammography Screening Rate	≥ Natl. HMO Avg. *	0.11%
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.

* Penalties are contingent on statistically meaningful differences from targets

EXHIBIT B

2017 KAISER PERMANENTE

City and County of Denver Employees
WELLNESS PROGRAM RENEWAL LETTER

August 17, 2016

City and County of Denver
Heather Britton
201 West Colfax Ave
Denver, CO 80202

Re: Kaiser Permanente HealthWorks Program

Dear Ms. Britton:
This letter constitutes the agreement between Kaiser Foundation Health Plan of Colorado, (KFHP) a Colorado nonprofit, public-benefit, corporation and City and County of Denver (CCD) with respect to the Workforce Health Package to be provided by KFHP to City and County of Denver as described in this letter.

Kaiser Permanente is proud to be a partner of City and County of Denver and we are committed to strengthening our collaboration through improving the health of your employees. City and County of Denver will receive the Workforce Health package for KP subscribers and KP non-subscribers from January 1, 2017 to December 31, 2017 valued at $100,000. In addition to the allocated funding, you will receive strategic workforce health consulting and 75 coordination hours to support your program. All 2017 programming will be decided upon and added as an appendix (operational plan) prior to December 31, 2016. *Please note wellness programs outside of the Kaiser Permanente menu must be requested and approved by Kaiser Permanente workforce health leadership prior to purchasing program.*

For the 2017 contract year, City and County of Denver had $200,000 in Workforce Health funding included in their monthly insurance premium rates paid to Kaiser Permanente by City and County of Denver to cover the costs of a third party vendor portal.

Kaiser Permanente agrees to provide the following:

- Workforce Health Consultant
- 75 hours of program coordination and implementation support.
- Employer Health and Wellness will partner with CCD wellness team to develop an operational plan for 2017 which will depict agreed upon programming, dates, communication deadlines, methods of data collection, reports, etc. by November 1, 2016 and will adhere closely to dates set forth. The operational plan will be updated and shared with CCD wellness team as changes to programming are made. Appropriate MOUs will be put into place with CCD once program details are finalized.

City and County of Denver commits to the following:

- Program planning and decisions will be made prior to completion of the operational plan. Any changes to program dates or operational plan from either party will be communicated 4 weeks or more prior to launch. This excludes necessary reschedules resulting from inclement weather and/or unforeseen circumstances.
- All changes to programming as originally set will be communicated to the Employer Health and Wellness team in a timely manner.
- Locations will be secured a minimum of 8 weeks prior to event.
- Any programs requested/proposed will be added separately to this agreement as amendments.

Please indicate your agreement to the terms of this letter agreement by signing this letter in the space indicated and returning it to:

Kaiser Permanente
HealthWorks
10065 E Harvard Ave., suite 250
Denver, CO 80231

Or email to:
Iffie.x.Jennings@kp.org

Signed:_____	Signed: _____
Kaiser Foundation Health Plan of Colorado By:	City and County of Denver By:
Title: _____	Title: _____
Date _____, 2016	Date:_____, 2016

EXHIBIT B-1

2017 KAISER PERMANENTE

City and County of Denver Employees
WELLNESS PROGRAM COMPREHENSIVE DOCUMENT

December 2, 2016

City and County of Denver

Re: Kaiser Permanente workforce health programs

This letter agreement ("Agreement") memorializes our previous discussions about the Kaiser Permanente workforce health programs that Kaiser Foundation Health Plan of Colorado for the Colorado Region ("Kaiser Permanente" or "KP") is providing or arranging for City and County of Denver ("Group"). KP and Group are collectively the "Parties," and each is a "Party." The services provided or arranged for under this Agreement are described in Exhibits A (any combination of Exhibits A-1, A-3, A-6, etc.) and are referred to in this Agreement as the "Services." The compensation rates applicable to Services are also included in Exhibits A. Exhibit B summarizes the Services chosen by Group and associated compensation rates.

ELIGIBLE GROUP PARTICIPANTS

Services will be available to certain Group participants as determined by Group, and the specific Group participants eligible for each Service are described in the various Exhibits A attached to this Agreement. Group participants include the following categories of participants:

Category of Group Participant	Description
1. KP-Subscribers	Group employees who are members of a KP health plan offered by Group (referred to as "KP-Subscribers")
2. KP-Subscriber-Dependents	KP-Subscribers' dependents aged 18 or older who are members of a KP health plan offered by Group (referred to as "KP-Subscriber-Dependents"
3. Non-Subscribers	Group employees who are not members of a KP health plan offered by Group (referred to as "Non-Subscribers")
4. Non-Subscriber-Dependents	Non-Subscribers' and KP-Subscribers' spouses and domestic partners aged 18 or older who are not members of a KP health plan offered by Group (referred to as "Non-Subscriber-Dependents")

The eligibility for any particular category of Group participant to access Services may vary by Exhibit and potentially within an Exhibit, and each Exhibit will control as to the availability of a Service to a particular Group participant.

SERVICES UNDER AGREEMENT

The Services are not regulated health plan benefits covered by KP when offered in the manner described in this Agreement. Group retains all responsibility for its group health plans' compliance with applicable law (including, as applicable, the Employment Retirement Income Security Act and its implementing regulations), as well as for its employee wellness programs' compliance with applicable law. KP does not provide legal advice to Group regarding the Services, and Group acknowledges its responsibility to consult with its own professionals for any legal advice regarding the Services.

INFORMATION NEEDED FROM GROUP

Where KP requires information or materials (for example, information about Non-Subscribers or access to space for work-site clinics) to perform its obligations under this Agreement, Group agrees to provide such information and materials (the "Required Materials," as described in Exhibits A). KP will have the right (and, if necessary, Group will obtain any third party rights necessary for KP) to copy, modify, and otherwise use Required Materials and any other content, information, records, and materials provided by or for Group to KP for the purpose of KP performing its obligations and exercising its rights under this Agreement. If KP does not receive the Required Materials in the specific manner and according to the terms set forth in this Agreement, KP will be under no obligation to provide the Services that require such Required Materials.

USE OF KP PROPRIETARY MATERIALS

With respect to Services provided by KP, Group acknowledges that, as between the Parties, KP will have all right, title and interest in and to: (a) all content, materials, reports, software and documentation, and any other works of authorship, analytical methodologies, data organization, processes, concepts, systems, know-how, ideas, inventions, and other technology, whether or not confidential, related to the Services, (b) all enhancements, modifications, improvements or derivatives to the foregoing (whether or not created by KP, alone or with others), and (c) all intellectual property rights related to the foregoing (collectively (a), (b) and (c) are referred to as the "KP Proprietary Materials"). Group will not acquire any proprietary rights or licenses in the KP Proprietary Materials.

KP grants to Group a non-exclusive, non-assignable, non-sublicenseable, non-transferable right to use any KP Proprietary Materials delivered to it by KP solely in connection with this Agreement. Upon the expiration or termination of this Agreement for any reason, Group will have a non-exclusive, non-assignable, non-sublicenseable, non-transferable right to continue to use the reports containing data as well as health education materials furnished by KP to Group under this Agreement. At all times, Group's use of the KP Proprietary Materials is subject to and conditioned on Group's compliance with the terms and conditions of this Agreement.

TERM AND TERMINATION

This term of this Agreement runs from January 1, 2017 ("Effective Date") through December 31, 2017, If Services are still in process at the time of expiration of the term, the Agreement will continue until the Services are fully performed. Either Party may terminate this Agreement with or without cause, upon 60 days written notice to the other Party. Expiration or termination of this Agreement shall not affect those rights, obligations, powers, remedies, and liabilities that arose prior to expiration or termination or are continuing in nature.

NOTICES

All notices, consents, requests, demands or other communications to or upon the respective Parties will be in writing and will be effective for all purposes upon receipt, including without limitation, in the case of (i) personal delivery, (ii) delivery by messenger, express or air courier or similar courier, (iii) delivery by United States first class certified or registered mail, postage prepaid and (iv) transmittal by facsimile, addressed to the respective address provided on the signature page. Changes in address will be communicated pursuant to this paragraph.

COOPERATION

Each Party may use affiliates, consultants or other contractors (together, "Delegates") in connection with the performance of its obligations and the exercise of its rights under this Agreement, provided that such Delegate will be subject to those obligations applicable to the delegating Party that are relevant to activities performed by Delegate.

Each Party will perform its obligations under this Agreement in a manner in accordance with all applicable laws and regulations. Where Group provides data on its employees to KP or a Delegate as necessary for performance of Services (for example, data on Non-Subscribers), Group agrees to follow applicable privacy law, including execution of a Business Associate Agreement where required. Each Party will cooperate with and participate in any activities reasonably necessary to assist the other Party in meeting its legal and regulatory obligations with respect to the Services, including cooperation with any review or examination of

the other Party by any governmental agency. Such cooperation and participation will include, without limitation, cooperation with reviews and audits of paper, electronic, or other files, except to the extent inconsistent with applicable law. In accordance with applicable law, KP may use aggregated data and information collected in providing the Services.

Each Party recognizes that the other Party and its affiliates own or have the license to use certain logos, trademarks, service marks and trade names that identify the other Party and its affiliates and contractors and its and their products and services ("Marks"). All goodwill resulting from use of a Party's and its affiliates' and contractors' Marks will inure solely to that Party, its affiliates or contractors, as applicable. Neither Party has acquired, and will not acquire, any right, title or interest in or to the other Party's or its affiliates' or contractors' Marks. Each Party and its affiliates will not register or attempt to register the Marks or any trademark or service mark confusingly similar to the Marks of the other Party, its affiliates or contractors, and will retain the exclusive right to apply for and obtain registrations for its Marks and those of its affiliates throughout the world.

INVOICES

For any amounts owed by Group to KP, KP will submit an invoice to Group describing the Services provided. Group will pay KP within 45 days after receipt of the invoice. Payments will be made in U.S. currency to the KP address provided by KP.

MISCELLANEOUS

This Agreement will be governed in accordance with the laws of the State of Colorado without reference to conflict of laws principles. This Agreement may be executed in separate counterparts, none of which need contain the signatures of both Parties, and each of which, when so executed, shall be deemed an original and all together constitute and be one of the same instrument. The Parties agree that a scanned or electronically reproduced copy or image of this Agreement bearing the signatures of the Parties will be deemed an original and will represent competent evidence of the execution, terms and existence of this Agreement notwithstanding the failure or inability to produce an original, executed counterpart of this Agreement, and without the requirement that the unavailability of such original executed counterpart of this Agreement first be proven. Any determination that any provision of this Agreement or any application thereof is invalid, illegal, or unenforceable shall not affect the validity, legality, and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. This Agreement contains the complete understanding among the Parties with respect to the subject matter of this Agreement and supersedes all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included. All Exhibits to this Agreement are incorporated into this Agreement by this reference. No changes, amendments, cancellation, or modification to this Agreement will be effective unless signed by duly authorized representatives of both Parties.

Please indicate your agreement with the terms of this Agreement by signing the enclosed copy of this Agreement and returning it to iffie.x.jennings@kp.org.

Very truly yours,

"Kaiser Permanente"

Kaiser Foundation Health Plan of Colorado

By:_____

Print Name: _____

Title:_____

Date:_____

Acknowledged and agreed to by:

"Group"

City and County of Denver

By:_____

Print Name: _____

Title:_____

Date:_____

EXHIBIT A-1

WORKSITE BIOMETRIC SCREENINGS AND SERVICES

1. Description of program

With a minimum requirement of thirty (30) Group participants for biometric screenings and flu vaccination clinics, KP will provide the worksite screenings and services described below.

Biometric Screenings and Flu Vaccinations:

Service	Description
Basic Screening Package (non-fasting)	Total cholesterol, High Density Lipoprotein (HDL) Glucose and Blood Pressure
Advanced Package (non-fasting)	Total cholesterol, HDL, Glucose, Blood Pressure, Measured Height & Weight, BMI & Body Fat %
Total Health Assessment Package (fasting required)	Total cholesterol, HDL, Low Density Lipoprotein (LDL), Triglycerides, Glucose, Blood Pressure, Measured Height, Weight & Waist Circumference, BMI and Body Fat %
Wellness Consultation/Coaching	One-on-one sessions with a wellness consultant to help participants understand lifestyle behavior changes that improve screening results
Flu Vaccinations	
Blood Pressure and Pulse Rate	
Measured Height, Weight & Waist Circumference	
Body fat % and BMI (using self-reported ht and wt)	
Glucose (non-fasting)	
Total Cholesterol (non-fasting)	

Group Participants Eligible for this Service

x	KP-Subscribers
	KP Subscriber-Dependents
	Non-Subscribers
	Non-Subscriber-Dependents

2. What needs to be supplied by Kaiser Permanente?

KP will provide the worksite biometric screenings and services noted above, as mutually agreed by the Parties.

3. What needs to be supplied by Group ("Required Materials")?

Group will provide the site location and other identified hardware, as well as at least 6 weeks advance notification of the date the worksite screenings and services are to take place.

4. Fee Schedule

[Include all that apply]

Service	Price
Screening	
Basic Screening Package (non-fasting)	$35 per participant
Advanced Package (non-fasting)	$42 per participant
Total Health Assessment Package (fasting required)	$49 per participant
Wellness Consultation/Coaching	$100 per hour for each consultant
Flu Vaccinations	$23 per participant
Blood Pressure and Pulse Rate	$75 per hour for each screener
Measured Height, Weight & Waist Circumference	$75 per hour for each screener
Body fat % and BMI (using self-reported ht and wt)	$75 per hour for each screener
Glucose (non-fasting)	$15 per participant
Total Cholesterol (non-fasting)	$20 per participant
Terms & Conditions	
Fees	• Total fees may vary by event, based on actual participation, event duration, staffing, event hours, travel fees, class customization, etc. Estimated event fees will be provided when event is scheduled. Total actual fees will be detailed on a post-event invoice, as applicable. o Additional staffing fees apply to services provided weekdays after 6:00 p.m. and before 7:00 a.m., and any time during weekends. o Additional fees may apply for non-standard event duration and/or non-standard staffing levels o Travel fees may apply, depending on event location, and will be quoted when event is scheduled. o Screenings priced hourly are subject to a 3-hour minimum, billed at $75 per staff hour. The full hourly rate will be charged for any partial hour. o Wellness Consultations are subject to 3-hour minimum per consultant. The full hourly rate will be charged for any partial hour. • Screenings and flu vaccination clinics will be charged at a minimum of 30 participants or 80% of estimated participation, whichever is greater, plus any additional fees if applicable.
Scheduling Guidelines	• All service requests must be submitted at least 6 weeks in advance in order to comply with permit application deadlines and staff scheduling lead-time. Requests submitted with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed. • Requests to increase number of attendees or event duration less than 10 business days before scheduled event date will be accommodated if possible, though cannot be guaranteed. Premium freight fees and supplemental staffing fees may apply. • Requests to decrease number of attendees or event duration less than 10 business days before scheduled event date cannot be accommodated. In such cases, billing will be based on most recent participation estimate and event schedule provided before 10 business day cutoff.

	• Requests to change event type less than 10 business days before scheduled event date will be accommodated if possible, though cannot be guaranteed. If requested changes cannot be accommodated, Group may reschedule, subject to rescheduling fee described below, or proceed with services confirmed before 10 business day cutoff.
Cancellation and Rescheduling	• If a confirmed event is cancelled less than 10 business days before event date, 50% of the total estimated event fees will be charged. • However, if a confirmed event is cancelled less than 5 business days before event date, 100% of total estimated event fees will be charged. • If a confirmed event is rescheduled less than 10 business days before event date, 25% of total event fees will be charged in addition to actual cost of rescheduled event. Rescheduling requests are subject to the 6 week lead-time described above. Rescheduling requests with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.

Credits

In connection with KP's mission to promote wellness in the community, the following credits will be applied to the Group's fees.

Services covered by credits	Screening package
Maximum Credit	$10,000
Time Period	January 1, 2017-December 31, 2017

EXHIBIT A-2

HEALTH PROMOTION PROGRAMS, CLASSES, AND WORKSHOPS

1. Description of the Program

KP will provide the health promotion services described below:

Health Promotion Programs:

Service	Descriptions	# Sessions
Back Care	Participants learn ways to keep their back as healthy as possible and avoid back problems by learning the basics in this interactive program. Participants will also learn basic back anatomy, posture, and work positioning that is beneficial to maintaining a healthy back	
Get Moving	Participants will learn guidelines for physical activity, the different types of physical activity, and explore ways to increase motivation and overcome barriers.	
Healthy Eating	Participants learn the principles of good nutrition as they apply to basic good health and help to lower the risk of developing certain chronic conditions. This class is quite helpful for those wishing to further improve control of conditions such as diabetes, heart disease, hypertension, and weight management.	
Quit Tobacco	Prepares participants to quit smoking by assessing their readiness, teaching them about the quitting process and developing their own quit plan.	

Stress Reduction	Describes the participant's body's "stress response," how to identify stress, and help combat these effects by providing an overview of stress management skills.	
Weight Management	Provides participants with an understanding of weight management principles, how to judge fad diets, diet aids, and to identify the behavioral aspects of weight control.	
Healthy Habits	Healthy living includes motivation, health change, and goal setting. After choosing a behavior they want to target – from exercise to flossing – participants will learn how to strengthen their motivation and make behavior changes that stick.	
Healthy Sleep	Sleeping well is vital to good health, well-being, and job performance. Participants will learn strategies to get the best night's sleep.	

Group Participants Eligible for this Service

x	KP-Subscribers
	KP Subscriber-Dependents
x	Non-Subscribers
	Non-Subscriber-Dependents

2. What needs to be supplied by Kaiser Permanente?

KP will provide Health Promotion Programs, Classes and Workshops on the dates and in the locations as mutually agreed by the Parties.

3. What needs to be supplied by Group ("Required Materials")?)

Group will provide the site location, room, projector, and other identified hardware.

4. Fee Schedule

Service	Price
Classes	
Single-Session Class	• $375 per one hour session • For extended class greater than one hour, $375 per portion of hour after first hour
Terms & Conditions	
Fees	• Total fees may vary by event, based on actual participation, event duration, staffing, event hours, travel fees, class customization, etc. Estimated event fees will be provided when event is scheduled. Total actual fees will be detailed on a post-event invoice, as applicable. o Additional staffing fees apply to services provided weekdays after 6:00 p.m. and before 7:00 a.m., and any time during weekends. o Additional fees may apply for non-standard event duration and/or non-standard staffing levels o Travel fees may apply, depending on event location, and will be quoted when event is scheduled. • Class participation is limited to 50 participants unless otherwise arranged at time of scheduling. Additional fees may apply for additional participants. • Additional fees may apply for customized classes and supplemental class materials which will be quoted at time of event scheduling.

Scheduling Guidelines	• All service requests must be submitted at least 6 weeks in advance in order to comply with staff scheduling lead-time. Requests submitted with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed. • Requests to increase number of participants greater than 50 participants that are submitted less than 10 business days before the scheduled event date will be accommodated if possible, though cannot be guaranteed. Supplemental staffing and material fees may apply. • Requests to decrease number of participants (if original request is greater than 50 participants) that are submitted less than 10 business days before the scheduled event date cannot be accommodated. In such cases, billing will be based on most recent participation estimate and event schedule provided before the 10 business day cutoff. • Requests to change class topic less than 10 business days before the scheduled event date will be accommodated if possible, though cannot be guaranteed. If requested changes cannot be accommodated, Group may reschedule subject to rescheduling fee described below, or proceed with services confirmed before 10 business day cut off.
Cancellation & Rescheduling	• If a confirmed event is cancelled less than 10 business days before event date, 50% of the total estimated event fees will be charged. • However, if a confirmed event is cancelled less than 5 business days before event date, 100% of total estimated event fees will be charged. • If a confirmed event is rescheduled less than 10 business days before event date, 25% of total event fees will be charged in addition to actual cost of rescheduled event. Rescheduling requests are subject to the 6 week lead-time described above. Rescheduling requests with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.

Credits

In connection with KP's mission to promote wellness in the community, the following credits will be applied to the Group's fees.

Services covered by credits	Health Promotion classes
Maximum Credit	$10,000
Time Period	January 1, 2017-December 31, 2017

EXHIBIT A-3
FACILITATED CONNECTIONS WITH OTHER WELLNESS COMPANIES

Curated Plus Arrangements

KP will facilitate Group's introduction to other wellness companies and will offer access for Group to KP's negotiated pricing for their services.

Wellness Company	Description of Services
Fruit Guys	Fresh Fruit Delivery Service
Health Enhancement Systems	Ready to implement wellness challenges including fitness, nutrition, weight control, stress management, and other health campaigns.
My Brain Solutions	Online emotional wellness solution
Weight Watchers Online*Plus*	Subscribers can follow the plan step-by-step entirely Online with interactive tools and resources like a weight tracker, progress charts, click to chat, restaurant guides and much more. Available in two versions specifically designed for men and women with tailored content that speaks directly to each audience.
Weight Watchers Meetings (includes Online*Plus*)	Gives members access to WW meetings at work and unlimited access to meetings in the local community along with eTools, internet weight-loss companion that helps members stay on track between meetings.
Weight Watchers for Diabetes (includes everything in *Meetings*)	Serves the unique needs of individuals with type 2 diabetes by integrating personalized coaching from a Certified Diabetes Educator (CDE) in the Weight Watchers proven approach. This option includes all of the benefits that come along with Weight Watchers Meetings.

Group Participants Eligible for this Service

x	KP-Subscribers
	KP Subscriber-Dependents
X	Non-Subscribers
	Non-Subscriber-Dependents

Fee Schedule

Wellness Company	Fee Schedule
Health Enhancement Systems	Price varies based on program.
My Brain Solutions	$ 0.32 PMPM
My Brain Solutions One time set up for customizing web site and communication materials 1. Implementation 8-week plan 2. Engagement Strategies	$2,500

Wellness Company	Fee Schedule
3. Communication Tools 4. Reporting	
My Brain Solutions Optional Single Sign On set up service to allow for ease of web access	$2,500
Weight Watchers Online*Plus*	$16.10 per month per employee
Weight Watchers Meetings (includes Online*Plus*)	$36.50 per month per employee
Weight Watchers for Diabetes (includes *Meetings*)	$56.06 per month per employee

Payment

As part of KP's mission to promote wellness in the community, KP agrees to credit Group for certain costs actually incurred by Group for eligible wellness services provided by the wellness companies and during the time period(s) noted below, up to the maximum dollar amount specified below. In the event that the fees for these wellness services to Group's participants exceed the maximum credits provided by KP, KP will invoice Group for the difference.

Name of Wellness Company Eligible for KP Credit	Dates of Service During Which KP Credit is Eligible	Maximum amount of KP Credit to Group for these Services
My Brain Solutions	January 1, 2017-December 31, 2017	$50,000
Weight Watchers	January 1, 2017-December 31, 2017	$50,000
Health Enhancement Systems	January 1, 2017-December 31, 2017	$10,000

EXHIBIT A-4

Wellness Ambassador Program

1. Description of Program

The Wellness Ambassador Program is a 9-week training curriculum that trains selected Group employees to become "Wellness Ambassadors" for other employees by enhancing knowledge about basic health and wellness and health insurance coverage. Through the Wellness Ambassador Program, employees will learn through practical class instruction, role playing and knowledge checks, how to become peer advocates and take the Group's existing wellness committee to the next level by creating a sustainable, onsite, social support system that influences healthy behavior change and enhances employee engagement.

Service:	Description:
1. Peer Wellness Coaching	Highlights roles, responsibilities, and provides education on the peer coaching model while initiating team building
2. Motivational Interviewing	Identifies basic elements of Motivational Interviewing (active listening, persuasion, etc.), and how to incorporate basic elements of MI into the Wellness Ambassador role
3. Health Plan 101	Familiarizes participants with health/wellness benefits, resources, and portals for all plans (for example KP members must be registered on kp,org and familiar with organization, content, tools, etc.)
4. Ready, Set, Goal	Facilitator leads participants in considering a health behavior change they have thought about making, identifying internal motivations, walking through the change process, and deciding on next steps
5. Stress Less	Provides an overview of how body, mind and symptoms are connected. Participants learn to identify sources of stress and the coping skills to help manage them.
6. Eating Well	Educates on principles of good nutrition as they apply to basic good health, including how a healthier diet can lower the risk of developing certain chronic conditions
7. Get Moving	Educates on the benefits of activity and how to develop an exercise plan, overcome barriers, and stay motivated
8. Weight Management	Educates on how healthy lifestyle choices and a positive attitude can help with weight loss and weight maintenance
9. Review and Graduation	Review of the previous 8 weeks of curriculum and graduation

Group Participants Eligible for this Service

x	KP-Subscribers
	Non-Subscribers

2. What needs to be supplied by Kaiser Permanente?

KP will provide classes on the dates and at the locations as mutually agreed by the Parties.

3. What needs to be supplied by Group ("Required Materials")?

Group will provide the site location, room, projector, and other identified hardware.

4. Fee Schedule

Service	Price
Class instruction and materials (for up to 25 people)	• $5,000
Terms & Conditions	
Scheduling Guidelines	• All service requests must be submitted at least 6 weeks in advance in order to comply with staff scheduling lead-time. Requests submitted with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.
Cancellation & Rescheduling	• If a confirmed event is cancelled less than 10 business days of event date, 50% of the total estimated event fees will be charged. • If a confirmed event is cancelled less than 5 business days of event date, 100% of total estimated event fees will be charged. • If a confirmed event is rescheduled less than 10 business days of event date, 25% of total event fees will be charged in addition to actual cost of rescheduled event. Rescheduling requests are subject to the 6 week lead-time described above. Rescheduling requests with less than 6 weeks' notice will be accommodated if possible, but are not guaranteed.

Credits

In connection with KP's mission to promote wellness in the community, the following credits will be applied to the Group's fees.

Services covered by credits	Wellness Ambassador Program
Maximum Credit	$25,000
Time Period	January 1, 2017-December 31, 2017

EXHIBIT C

2017 KAISER PERMANENTE

DENVER LOGO GUIDELINES

DENVER

THE MILE HIGH CITY

CITY AND COUNTY OF DENVER LOGO GUIDELINES

These guidelines demonstrate how to correctly use the City and County of Denver logo.

UPDATED 2016



CONTENTS

TYPES OF LOGO FILES

EPS
Vector-based image that will not lose quality if scaled larger than the provided size. Available in four color process, spot color and black and white. Primarily used for professional printing.

JPEG
Both high and low-resolution pixel-based images that will lose quality if scaled larger than the provided size. Available in RGB format and black and white. Primarily used for in-house printing and for viewing on screen. This is also the preferred format for programs that are not design-based, such as Microsoft Word, Microsoft Excel, and Microsoft PowerPoint.

TYPES OF LOGO COLORS

Spot Color
Spot color printing uses pre-mixed ink colors determined by the Pantone Matching System (PMS). They accurately represent color chips provided to the print and design industry.

4 Color Process
Process printing uses four inks (cyan, magenta, yellow and black — also referred to as CMYK) printed together to create a wide spectrum of colors.

RGB Format
Colors are used in RGB (red, green and blue) format when they appear on computer or television screens.

Hex Numbers
Hexadecimal numbers or “hex” numbers are a base-16 numbering system used to define colors on web pages. A hex number is written from 0-9 and then A-F.

For copies of the logo in any format or questions about which file type you need, please contact the Denver Marketing Office at DenverMarketingOffice@DenverGov.org or 720-913-1633.



WHO CAN USE THE CITY AND COUNTY OF DENVER LOGO

DENVER
THE MILE HIGH CITY

DENVER
THE MILE HIGH CITY

The Denver D logo is available for use by city employees of the City and County of Denver for city department/agency purposes. The Denver logo may not be distributed to external entities (with the exception of the partnering agencies described below) without a licensing agreement.

The Denver D logo may be distributed to entities with which the City and County of Denver has executed a contract that includes, at a minimum, the following terms and conditions: required usage guidelines to include duration of use; purpose of use; and the corresponding collateral in which the Denver D logo will be placed. Licensing agreements may be obtained through the Denver Marketing Office and are subject to Executive Order No. 8.

For an outside entity to be considered for a licensing agreement authorizing them to use the Denver D logo, the city must be playing an active role in event or partnership or have a paid, documented sponsorship agreement. When the city does enter into a relationship as a sponsor, the sponsorship package must include phrasing that defines the acknowledgement of city support through the use of its logo to be eligible. For a copy of the city's sponsorship agreement please contact the Denver Marketing Office.

The city does not provide use of the logo for events or initiatives for which the city has supplied grant-funded support unless the event or initiative has a corresponding documented sponsorship component or agreement. If the city has provided a grant to an outside entity, that entity may recognize city support through written or spoken word unless the grant or contract providing grant funds provides otherwise.

The City and County of Denver does grant permission to use the Denver D logo to the city's exclusive partners, such as the VISIT DENVER, the Convention and Visitors Bureau and the Downtown Denver Partnership. All partnering agencies must follow the usage guidelines as described in the graphic standards. Distribution of the logo to outside entities by partnering agencies is unacceptable.



PRIMARY AND SECONDARY LOGOS

The City and County of Denver logo consists of three main elements: The primary D icon, the DENVER logotype and tagline.

Each of these elements has been custom-created and should never be recreated or re-typeset. To maintain consistency and create a strong visual identity, the Denver logo should only be used from existing digital files.

Please DO NOT use the Denver D icon without the DENVER logotype and tagline unless expressly permitted by this guide or the Denver Marketing Office.

PRIMARY LOGO
The horizontal version of the Denver logo (D icon to the left of the logotype) is the preferred logo format.

The logo utilizes the typeface Avenir Black for both DENVER and the tagline.

The distance to the right of the D icon and to left of the type should remain consistent. This distance is determined by the distance between the bottom of the tagline to the bottom of the DENVER logotype, represented by the letter X. The distance from the right edge of the D icon to the left edge of the logotype should be equal to X. The block of text in its entirety is centered vertically with the D icon.

SECONDARY LOGO
When the horizontal version of the Denver logo will not work with your space or design requirements, the secondary, stacked logo version can be used. Again, the distance between the bottom of the D icon and top of the DENVER logotype should be equal to X. The block of text in its entirety is centered horizontally with the D icon.



CLEAR ZONE, MINIMUM SIZES & TYPEFACES

CLEAR ZONE

The Denver logo should always have an area of open space or “clear zone” around it. No other graphic elements should fall within this area around the logo.

Where “X” is equal to the distance between the bottom of the tagline to the bottom of the DENVER logotype, leave at least X amount of clearance on all sides of the logo.

7/8"

5/8"

MINIMUM SIZES

The Denver logo should always be used at an appropriate size to make sure it is legible.

When the primary signature is used, it should be no smaller than 7/8” wide at the widest point. The secondary signature should be used no smaller than 5/8” at its widest point.

ITC Franklin Gothic Demi
ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890@#$%^&*!?/:;.”{}[]()

ITC Franklin Gothic Book
ABCDEFGHIJKLMNOPQRSTUVWXYZ
abcdefghijklmnopqrstuvwxyz
1234567890@#$%^&*!?/:;.”{}[]()

TYPEFACES

The primary typeface used to accompany the Denver logo is ITC Franklin Gothic.

There are two typefaces in this family that are commonly used for Denver branded materials: Franklin Gothic Demi and Franklin Gothic Book.

Standard fonts such as Arial are permitted within documents created in programs where custom fonts are not available.



LOGO COLORS

The Denver logo color palette is comprised of five colors that represent this vibrant city.

Spot-color printing is the preferred option and should be used whenever possible. However, four-color process printing may be used when spot-color printing is not available or cost effective. When the logo is used on the on screen, the RGB format should be used and hex values should be used for the web. The Denver logo spot colors and their corresponding four-color process, RGB and hex formulas are listed below.

The color samples in this guide are just a visual representation of the colors and should not be used as an accurate color match. Actual Pantone chips should be used to match colors when printing.

	SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
BRICK RED	PMS 1805	C 0 M 91 Y 100 K 23	R 160 G 0 B 34	#C4161C
SKY BLUE	PMS 2925	C 85 M 24 Y 0 K 0	R 0 G 150 B 214	#0096D6
SUNSHINE GOLD	PMS 130	C 0 M 30 Y 100 K 0	R 253 G 185 B 19	#FDB913
MOUNTAIN PURPLE	PMS 268	C 82 M 100 Y 0 K 12	R 64 G 15 B 96	#491D74
80% BLACK	PANTONE PROCESS 80% BLACK PMS 425	C 0 M 0 Y 0 K 80	R 88 G 89 B 91	#58595B

Note: Palette colors pertain to both coated and uncoated stocks



REVERSE & ONE-COLOR USAGE

DENVER
THE MILE HIGH CITY

DENVER
THE MILE HIGH CITY
15%

DENVER
THE MILE HIGH CITY
50%

DENVER
THE MILE HIGH CITY
70%

FULL-COLOR REVERSE USAGE
A reverse version of the Denver logo has been developed for use when the logo appears on black or other dark colors. The D is not actually reversed, but uses a white border to separate it from the background. The logotype and tagline are white instead of black to increase legibility.

Use the regular signature on backgrounds with a color that has a tonal equivalency of 15% or less black and the reverse signature on backgrounds with a color that has a tonal equivalency of more than 15% black.

DENVER
THE MILE HIGH CITY

ONE-COLOR USAGE
An alternate version of the Denver logo has been developed to be used when only one color is available.

One-color logos should only be used as an alternative to the preferred full-color version. It should not be used in four-color process printing or in RGB formats, where you can use a full-color version instead.

DENVER
THE MILE HIGH CITY

ONE-COLOR REVERSE USAGE
When only one color is available and the logo appears on black or another dark color, a one-color reverse usage should be used. In this version, the primary D icon is used with a white border with the colored elements reversed to the background color.



INCORRECT USAGE

DO NOT reposition the elements of the logo.

DO NOT use the one-color reversed logo where the primary icon appears in solid white (see page 5 for the correct usage).

DO NOT change the colors of the logo.

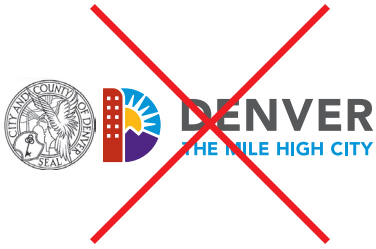
DO NOT distort or stretch the logo. Make sure it is always scaled proportionally.

DO NOT use the primary D icon as a decorative capital letter.

DO NOT place the logo on a background without sufficient contrast (see reverse applications on page 5).

DO NOT place the logo on a photographic background without sufficient contrast (see reverse applications on page 5).

DO NOT use the logo without all of the necessary elements.



DO NOT use the logo or primary icon in a way that violates the minimum clear space, especially in a co-branding situation.

DO NOT use the D icon locked up with any other typeface.



THE CITY FLAG AND THE CITY SEAL

THE CITY FLAG

The city flag graphic is not to be used as a replacement for the Denver D logo. The city flag image is to be associated only with an actual flag representing the City and County of Denver. All materials currently showcasing the city flag as a graphic image need to be phased out and replaced with the D logo (e.g., employee badges, city vehicles, brochures, etc.).

The city flag image is protected by common law rights.

THE CITY SEAL

The city seal is to be reserved for official city documents. Official documents include, but are not limited to, mayoral proclamations, legal documents and death certificates.

To the extent reasonable, city agencies and departments must transition to the updated business systems package for regular city business. The business system package includes letterhead, envelopes, and business cards which are available on the brand center. As appropriate, all marketing, informational and informal material – including websites, uniforms, brochures and other collateral material – should include the Denver D logo and exclude the city seal.

If you have any questions regarding logo usage policies please contact the Denver Marketing Office. If you have any questions regarding legal considerations around the use of the city seal, please contact the City Attorney's Office.



OFFICES WITHIN THE CITY

Offices within the city are able to use their own unique logo, as outlined below. It is also acceptable for the office to use the main City and County of Denver logo if they choose.

DEPARTMENTS AND AGENCIES

To maintain the integrity of the City and County of Denver logo when branding departments, offices and agencies within the city, the logo will still be comprised of three elements. The D icon and DENVER logotype will remain, but the name of the department will take the place of the tagline, THE MILE HIGH CITY. Please keep the DENVER logotype alignment the same as the main City and County of Denver logo.

When the name of the department is too long to fit onto one line, the text should flow to the second (or third, if applicable) line. The top of the department name will remain on the same level. Please try to split the name evenly onto two lines, and do not extend the name of the department further than approximately 50% beyond the length of DENVER. Please refer to **page 5** for reverse and one-color usage.

Please do not use the word “DENVER” in department name to avoid redundancy, and acronyms in the department name should be avoided whenever possible.

DIVISIONS WITHIN DEPARTMENTS AND AGENCIES

When branding programs that are contained within the city’s departments, offices and agencies, a new type configuration applies. The name of the program is set first in the position and ratio indicated below. The name of the parent department, office or agency moves to the second line, and always follows the word “Denver.”

If the name of the program is too long to fit onto one line, it should flow to the second line.

As with the primary Denver logo, the distance to the right of the D icon and to left of the type should remain consistent within program logos. Note that in these applications, all text elements move to align to the top of the D icon.

TAGLINES

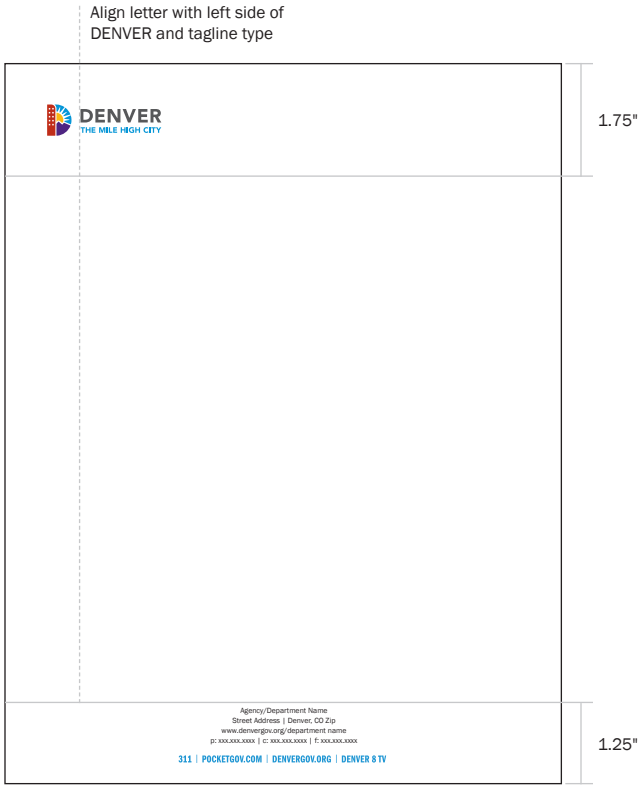
Please do not lock up taglines, mission statements, etc. to the logo when creating an office’s identity.

EXCEPTIONS

The three divisions of the Department of Safety and Denver International Airport are the only city offices that are permitted to continue using independent logos. The Denver D logo should still be co-branded with these agencies whenever appropriate.



LETTERSET



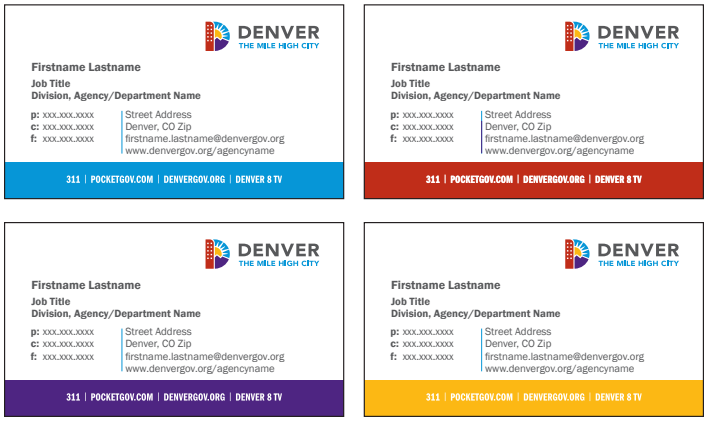
LETTERHEAD

This letterhead has also been set up as a Microsoft® Word template.

If the document is released from multiple divisions, please typeset only the primary department/agency contact information centered across the bottom to avoid confusion and maintain the specified layout.

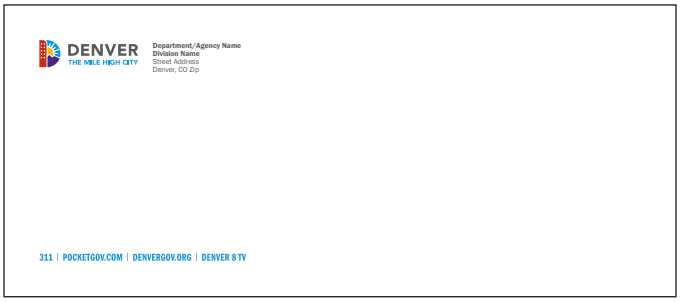
When typing a letter, align the left side of the text with the left side of the DENVER and tagline typography and begin typing 1.75" from the top of the page.

Leave a 1.25" margin at the bottom of the page to accommodate contact information.



BUSINESS CARDS

Visit the Brand Center at www.denvergov.org/brandcenter for electronic files and pre-printed shells. Do not attempt to recreate the business card artwork. Please do not add logos or other artwork to the back of the card.



#10 ENVELOPE

Visit the Brand Center at www.denvergov.org/brandcenter for electronic files and pre-printed shells. Do not attempt to recreate the envelope artwork.

For additional templates not provided within this document (i.e. pocket folders, press releases, presentations, etc.) please contact the Denver Marketing Office.



EMAIL SIGNATURES AND MOBILE GUIDELINES

DENVER
THE MILE HIGH CITY

First Name N. Lastname | Job Title
Division, Agency/Department | City and County of Denver
p: (xxx) xxx-xxxx | name.name@xxxxxxxxxxdenvergov.org

CONNECT WITH US | 311 | pocketgov.com | denvergov.org | Denver 8 TV | Facebook

EMAIL SIGNATURES

Email signatures should feature the horizontal version of the City and County of Denver logo below the email sender's information. Directly below this, the signature should additionally contain the city's four connection touch-points as illustrated in the example image on the right. This text graphic represents the four most common ways in which residents connect with the city for services, schedules, and information.

Please use a text-only version of the signature when responding to email changes so as not to unnecessarily increase the message file size. Agency or department specific logos, per page 8, are permitted in email signatures. However, it is the sole responsibility of the communications director in each department to create and distribute these templates in order to ensure that the graphic standards are maintained.

Personal quotes, background colors and patterns, etc., should not be used in the email signature. However, department mission statements are acceptable when necessary. It is also permissible to add certain standardized language, such as legal disclosure policies or requests to minimize paper usage.

Please note that Arial is used in place of Franklin Gothic in this application because it is a web-safe font.

Please refer to the Denver Brand Center to properly set up your email signature.



APP ICONS

Departments, agencies, divisions and programs within the City and County of Denver may have the opportunity to create mobile apps. When doing so, any primary, secondary or accent color can be utilized.

Glyph icons are used for mobile application toolbars, splash screens, navigation, and menus. Mobile application glyph icons must be designed as monochromatic symbols with an emphasis on minimalism and simplicity. Mobile app icons must provide easy recognition in formats as small as 32 x 32 pixels and must adhere to all size standards provided by the specific mobile application framework (iOS, Android, Windows Phone, etc.). They should be developed in vector format to be scalable up or down, depending on the required specifications.

The app icon should feature a simple, representative image reversed out on a city color. The icon should feature a solid color border and an embossed effect to give it dimension. Examples are at left; please note that customized icons should be approved by the Denver Marketing Office before they are used.



PROGRAM, VENUE AND EVENT LOGOS

DENVER
THE MILE HIGH CITY

Any office operating solely under the City and County of Denver, exclusively funded with taxpayer dollars and/or at the direction of the mayor should be using the Denver D as its primary logo. However, there are instances when a city program, venue or event may merit its own visual identity, such as in the case of a partnership with an external entity, when the initiative needs to be marketed broadly, or when legal or political considerations make the Denver D less preferred. In those scenarios, some basic quality assurances should be considered.

Please contact the Denver Marketing Office before a new logo is created.

Some guidelines to consider when designing a new program identity:

- **Logos & Symbols**
  Style matters. The symbol reflects Denver's energy, the amazing weather, outdoor lifestyle and economic vitality through the incorporation of the shining sun, blue skies, majestic mountains and downtown landscape. When creating a new program identity, try to be compatible with the design feel established by the Denver "D" icon.
- **Brand Recognition**
  It's important for our audiences to understand which programs are affiliated with the city. Please use the City and County of Denver logo and identity prominently on all materials. In applications where the Denver D cannot be featured prominently, such as on an independent website, please include prominent text explaining the affiliation with the city (e.g. "Red Rocks Amphitheater is a proud venue of the City and County of Denver.")
- **Co-Branding**
  Consider what other logos will appear with the new one and try to complement, instead of compete with them.
- **Color Palette**
  Always use colors from the approved palette. See page 12 for expanded colors.
- **Typefaces**
  When it comes to font personality, a little goes a long way. Try to stay within the Franklin Gothic font family when possible.
- **Simplification**
  Logos should rarely have more than a couple colors and distinct elements (mark, typeface, tagline).
- **Scalability**
  Logos should have the ability to be used in very large or very small formats, meaning that high resolution versions should be developed and too many elements should be avoided.
- **Section 508 Web Color Contrast**
  Web Content Accessibility Guidelines (WCAG 1.0) require that there be a sufficient level of tonal contrast between colors so that low-vision users can read content on colored backgrounds. Guidelines for ensuring color combinations include:
  - Select color combinations that can be differentiated by users with color deficiencies;
  - Use tools to see what color combinations will look like when in black and white as seen by color-deficient users;
  - Ensure that the lightness contrast between foreground and background colors is high;
  - Increase the lightness contrast between colors on either end of the spectrum (e.g., blues and reds); and
  - Avoid combining light colors from either end of the spectrum with dark colors from the middle of the spectrum.

Please contact the Denver Marketing Office with any questions regarding program identity best practices.



EXPANDED PALETTE

DENVER
THE MILE HIGH CITY

Although the main logo is comprised of five colors, city programs may use colors in the expanded palette for identity development and other graphic design. The expanded palette includes four secondary colors and four accent colors.

PRIMARY PALETTE

SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
PMS 1805 BRICK RED	C 18 M 0 Y 100 K 31	R 159 G 166 B 23	#9FA617
PMS 2925 SKY BLUE	C 100 M 58 Y 0 K 21	R 0 G 85 B 150	#005596
PMS 130 SUNSHINE GOLD	C 0 M 51 Y 100 K 1	R 243 G 144 B 29	#F3901D
PMS 268 MOUNTAIN PURPLE	C 0 M 79 Y 100 K 11	R 217 G 83 B 30	#D9531E
PANTONE PROCESS 80% BLACK 80% BLACK			

SECONDARY PALETTE

SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
PMS 384 YELLOW GREEN	C 18 M 0 Y 100 K 31	R 159 G 166 B 23	#9FA617
PMS 294 BRIGHT BLUE	C 100 M 58 Y 0 K 21	R 0 G 85 B 150	#005596
PMS 152 ORANGE	C 0 M 51 Y 100 K 1	R 243 G 144 B 29	#F3901D
PMS 180 RED ORANGE	C 0 M 79 Y 100 K 11	R 217 G 83 B 30	#D9531E

ACCENT COLORS

SPOT COLOR (PANTONE)	4 COLOR PROCESS (CMYK)	RGB	HEX COLOR (WEB)
PMS 296 NAVY	C 100 M 46 Y 0 K 70	R 0 G 45 B 86	#002D56
PMS 7496 BRIGHT GREEN	C 40 M 0 Y 100 K 38	R 109 G 141 B 36	#6D8D24
PMS 420 LIGHT GRAY	C 0 M 0 Y 0 K 15	R 220 G 221 B 222	#DCDDDE
PMS 7501 CREAM	C 0 M 4 Y 20 K 6	R 241 G 227 B 197	#F1E35C

Note: Palette colors pertain to both coated and uncoated stocks



EXPANDED PALETTE: SUGGESTED USAGE

DENVER
THE MILE HIGH CITY

When selecting colors for a new program identity, please choose from the primary and expanded palette.

While it is not required to use a primary palette color, it is recommended to maintain brand recognition throughout subbbrands.

Example Palette 1

Example Palette 2

Example Palette 3

You may use up to all four colors in the secondary palette, but please do not exceed five colors overall in identity development.

Example Palette 1

Example Palette 2

Example Palette 3

If you are using one or more accent color (up to three), please use at least one color from the primary or secondary palette.

Do not use a color from the accent palette as the dominant color in the application.



ALLIED ORGANIZATIONS AND CO-BRANDING

EXISTING ALLIED ORGANIZATIONS

It is recognized that there are several organizations that are closely aligned with the City and County of Denver, which each have their own brand personality. Examples of these organizations include the Denver Zoo, the Denver Botanic Gardens, Denver Water, and Denver Public Schools. These organizations are not required to rebrand to align with the new branding standards.

DENVER BOTANIC GARDENS

x

DENVER
THE MILE HIGH CITY

.75 X

ALLIED ORGANIZATION CO-BRANDING WITH THE CITY OF DENVER

Allied organizations with their own brand personality are not required to include the City and County of Denver logo on their collateral. However, if they decide to do so and have met the requirements outline on page 1, the City and County of Denver logo usage must comply with this guide and it must visually be at least 75% of the allied organization's logo. Additionally, please do not lockup the allied organization and City and County of Denver's logo, or use parts of the Denver logo within the allied organization's logo. Maintain clear space defined on **page 3**.

DENVER BOTANIC GARDENS

DENVER
THE MILE HIGH CITY

(Maintain clear area defined on p. 3)

CO-BRANDING PARTNERING AGENCIES AND SPONSORS

The City and County of Denver often partners with outside entities to promote a program or service. When partnering with outside organizations it is acceptable, if granted permission by both entities, to place their logos side by side with the Denver D.



GLOSSARY OF TERMS

Accent Color — A palette chosen to accent or support main colors utilized in identity development.

Clear Zone — Logo guidelines often specify a clear zone surrounding the logo. No other art or type should encroach on the clear zone.

Co-Branding — If two logos appear together to imply a cooperative effort, it is called co-branding. Logos used in co-branding should always respect the necessary clear space surrounding each logo.

Digital File — Digital files that are prepared by graphic designers to be printed or to be uploaded to web sites.

Foreground — The visual plane in an image closest to the viewer.

Four-Color Process — Process printing uses four inks (cyan, magenta, yellow and black — also referred to as CMYK) printed together to create a wide spectrum of colors.

Graphic Standards — An organization's requirements for reproducing its graphics and branding elements on all surfaces.

Glyph Icons — A graphic symbol that provides the appearance or form for a character. A glyph can be an alphabetic or numeric font or some other symbol that pictures an encoded character.

Hex Colors — Hexadecimal numbers or "hex" numbers are a base-16 numbering system used to define colors on web pages. A hex number is written from 0-9 and then A-F.

Lockup — The final form of a logo and a icon with all of the elements locked in their relative positions. For the sake of maintaining consistency in all mediums and to create a sense of cohesion between the elements, the lockup should not be taken apart or altered in any way.

Logotype — Logotype refers specifically to a word integrated into the logo.

Mobile Application — Also known as an app, a mobile application is a term used to describe software that runs on smart phones and mobile phones.

Monochromatic — Containing or using only one color.

Navigation — A user interface element within a webpage that contains links to other sections of the website.

Pixels — A physical point in a raster image, or the smallest addressable element in a display device; so it is the smallest controllable element of a picture represented on the screen.

Primary Icon — An organization's predominant mark; the preferred logo to be used on collateral.

Primary Palette — The main colors that comprise an organization's identity.

Raster Image —In computer graphics, a raster image, or bitmap, is a dot matrix data structure representing a generally rectangular grid of pixels, or points of color, viewable via a monitor, paper, or other display medium. Raster images are stored in image files with varying formats.

Re-Typeset — To re-typeset essentially means to re-type. It is never acceptable to re-type the words in a logo or tag line; instead always use the artwork provided.

Reverse Logo — A reverse logo is used when a logo appears on a dark background color that doesn't provide enough contrast. In order to make the logo more legible, the logo colors are changed to white.

RGB Format — Colors are used in RGB (red, green and blue) format when they appear on computer or television screens.

Scalable — An icon or logo's ability to be reduced or blown up in size.

Secondary Palette — Colors chosen to support the primary palette in an organization's identity.



GLOSSARY OF TERMS CONTINUED

Splash Screen — An image that appears while a computer program is loading. It may also be used to describe an introduction page on a website.

Spot Color — Spot color printing uses pre-mixed ink colors determined by the Pantone Matching System (PMS). They accurately represent color chips provided to the print and design industry.

Tagline — Tagline refers to a few word description that often accompanies a logo to make it more descriptive.

Tonal Contrast — The difference between the light and dark areas in a composition.

Typeface — Typeface is the same as “font.” A font or typeface is a professionally designed alphabet. Most logo guidelines specify the typeface to use with the logo.

Typesetting — Before computers became a part of design and printing, words were prepared for print by manually setting individual letters in the right sequence: “typesetting.” The term is still used to describe preparation of letters and words for print. If you choose a font and letter size for placement in a document, you are “typesetting.”

Vector — An image made up of solids, lines and curves that can be scaled or edited without affecting image resolution.

Web-Safe Font — A set of fonts that appear on a large percentage of computers. Common Web-safe fonts include: Arial, Courier New, Times New Roman, Georgia, Trebuchet, and Verdana.