FIRST AMENDMENT

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

RECITALS

WHEREAS, the Parties previously entered into an agreement identified with contract number CSAHR 202263753-00 dated June 05, 2024 ("**Agreement**") for the Contractor to provide services described therein; and,

WHEREAS, the Parties intend to amend the Agreement to: update Exhibit A-2 with 2025 policy information, update Exhibit A-3 with 2025 performance metrics, extend the term of the agreement; and, to increase the maximum contract amount as described herein.

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

1. Exhibit A-2 shall be updated and replaced with the 2025 policy information attached hereto and marked "**Exhibit A-2**".

2. Exhibit A-3 shall be updated and replaced with the 2025 performance metrics attached hereto and marked as "**Exhibit A-3"**.

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

> "4**.** **TERM:** This Agreement is effective beginning on **January 1, 2023**, and shall expire at 11:59 p.m. on **December 31, 2025** (the "**Term**")."

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

> "**5. COMPENSATION AND PAYMENT:**
>
> (d)(1) **Maximum Contract Amount:** Notwithstanding any other provision of the Agreement, the City's maximum payment obligation will not exceed **TWO HUNDRED EIGHTY-ONE MILLION DOLLARS AND NO CENTS ($281,000,000.00)** (the "Maximum Contract Amount"). The Maximum Contract Amount is comprised of: $97,000,000.00 for 1/1/2023-12/31/2023 covering the City and County of Denver #75, Denver Police Department #68 and Denver Fire Department #74; $91,000,000.00 for 1/1/2024-12/31/2024, covering the City and County of Denver #75 and Denver Police Department #68; and $93,000,000.00 for 1/1/2025-12/31/2025, covering the City and County of Denver #75 and Denver Police Department #68 The City is not obligated to execute an Agreement or any amendments for any further services, including any services performed by Contractor beyond that specifically described in Exhibit A. Any services performed beyond those in Exhibit A are performed at Contractor's risk and without authorization under the Agreement.

5. Modification of Section 10 Insurance. Paragraph 10(c) of the Agreement (entitled "Additional Insureds") is hereby amended and restated to read as follows:

c. Additional Insureds: For Commercial General Liability. Contractor and subcontractor's insurer(s) shall include the City and County of Denver as additional insured.

6. Modification of Section 29 Confidential Information. A new Paragraph 29(b) of the Agreement (entitled "Gag Clause Prohibition") is hereby created, and shall read as follows:

b. Gag Clause Prohibition. The Parties agree that no term contained in this Agreement shall be interpreted to violate the gag clause prohibition pursuant to Internal Revenue Code (Code) section 9824, Employee Retirement Income

Security Act (ERISA) section 724, and Public Health Service (PHS) Act section 2799A-9, as added by section 201 of Title II (Transparency) of Division BB of the CAA, as may be applicable. Any questionable term shall be interpreted and enforced such that the City may truthfully sign the annual required Gag Clause Prohibition Compliance Attestation.

7. Modification of Personal Information and Data Protection. Paragraph 33(a) of the Agreement (entitled "Data Protection Laws") is hereby amended and restated to read as follows:

a. "Data Protection Laws" means (i) all applicable federal, state, provincial and local laws, rules, regulations, directives and governmental requirements relating in any way to the privacy, confidentiality or security of Personal Information (as defined below in Paragraph 25.B) applicable to Contractor; and (ii) all applicable laws and regulations relating to electronic and non-electronic marketing and advertising; laws regulating unsolicited email communications; security breach notification laws; laws imposing minimum security requirements; laws requiring the secure disposal of records containing certain Personal Information; laws imposing licensing requirements; laws and other legislative acts that establish procedures for the evaluation of compliance; and all other similar applicable requirements that are applicable to Contractor. Further, and not by way of limitation, Contractor shall provide for the security of all City Data, and Personal Information if applicable, and all applicable laws, rules, policies, publications, and guidelines including, without limitation: (i) the most recently updated PCI Data Security Standard from the PCI Security Standards Council for all PCI, (ii) Colorado House Bill 18-1128.

8. Modification of Personal Information and Data Protection. Paragraph 33(d) of the Agreement (entitled "Software Programs; Security of Personal Information and access to Software Programs") is hereby amended and restated to read as follows:

d. Software Programs; Security of Personal Information and access to Software Programs: Contractor will use the software programs authorized by the Contractor to collect, use, process, store, or generate all data and information, with or without Personal Information, received as a result of the Contractor's services under this Agreement. In addition, Contractor will establish and maintain data privacy and information security policies and procedures, including physical, technical, administrative, and organizational safeguards, in order to: (i) ensure the security and confidentiality of Personal Information; (ii) protect against any anticipated threats or hazards to the security or integrity of Personal Information; (iii) protect against unauthorized disclosure, access to, or use of Personal Information; (iv) ensure the proper use of Personal Information; and (v) ensure that all employees, officers, agents, and subcontractors of Contractor, if any, comply with all of the foregoing. Contractor shall also provide for the security of all Personal Information in accordance with HIPAA Security Rule, as amended, and all applicable laws, rules, policies, publications, and guidelines including, without limitation: (i) the Children's Online Privacy Protection Act (COPPA), and (ii) Colorado House Bill 18-1128. The Contractor shall submit make available to the Executive Director, after written request, copies of the Contractor's policies and procedures to maintain the confidentiality of Personal Information to which the Contractor has access based on an agreed upon timeline.

9. Modification of Personal Information and Data Protection. Paragraph 33(f) of the Agreement (entitled "Contractor Use of Personal Information and City Work Product") is hereby amended and retitled as "Contractor Use of Personal Information".

10. Modification of Personal Information and Data Protection. Paragraph 33(h) of the Agreement (entitled "Loss of Personal Information or City Work Product") is hereby amended and restated to read as follows:

h. Loss of Personal Information or City Work Product: In the event of any

act, error or omission, negligence, misconduct, or breach that compromises or is suspected to compromise ("Breach" or "Suspected Breach" as defined in C.F.R. Section 164.402) the security, confidentiality, or integrity of Personal Information or City Work Product, Contractor will, as applicable: (i) notify the affected individual as required by applicable law and the City as soon as practicable but no later than seventy-two (72) hours of becoming aware of such occurrence affecting members enrolled in City plan; (ii) in the case of Personal Information and if required by applicable law, at the affected individual's sole election: (A) notify the affected individuals in accordance with any legally required notification period; or , (B) reimburse the affected individual for any costs in notifying the affected individuals; (iv) in the case of Personal Information and if required by applicable law, provide third-party credit and identity monitoring services to each of the affected individuals for the period required to comply with applicable law; (v) perform or take any other actions required to comply with applicable law as a result of the occurrence; (vi) indemnify, defend, and hold harmless the City and the affected individual for any and all claims, including reasonable attorneys' fees, costs, and expenses incidental thereto, which may be suffered by, accrued against, charged to, or recoverable from the City or the affected individual in connection with the occurrence ; (v) where applicable and feasible, be responsible for recovering lost data and information in the manner and on the schedule agreed upon by the City and Health Plan without charge to the affected individual, and (vi) provide to the City a detailed plan based on mutually agreeable timeframe as warranted by the severity of the Breach of the occurrence describing the measures Contractor will undertake to prevent a future occurrence. Notification to affected individuals, as described above, will comply with applicable law, be written in plain terms in English and in any other language or languages specified by the affected individual, and contain, at a minimum: (i) name and contact information of Contractor's representative; (ii) a description of the nature of the loss; (iii) a list of the types of data involved; (iv) the known or approximate date of the loss; (v) how such loss may affect the affected individual, and; (vi) what steps Contractor has taken to protect the affected individual;

what steps the affected individual can take to protect himself or herself. This Section will survive the termination of this Agreement.

11. Modification of Personal Information and Data Protection. Paragraph 33(i) of the Agreement (entitled "Loss of Personal Information or City Work Product") is hereby amended and restated to read as follows:

i. Data Retention and Destruction: Using appropriate and reliable storage media, Contractor will regularly backup all Personal Information used in connection with this Agreement and retain such backup copies consistent with the Contractor's data retention policies. The Parties acknowledge and agree that Health Plan will retain PHI as defined by HIPAA at 45 CFR Section 164,103, subject to all applicable laws. Contractor shall continue to preserve the records until further notice by City. This Section will survive the termination of this Agreement.

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

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

[SIGNATURE PAGES TO FOLLOW]

Contract Control Number: CSAHR-202263753-01
Contractor Name: KAISER FOUNDATION HEALTH PLAN OF COLORADO

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

SEAL

CITY AND COUNTY OF DENVER:

ATTEST:

By: _____

_____

APPROVED AS TO FORM:

Attorney for the City and County of Denver

By: _____

REGISTERED AND COUNTERSIGNED:

By: _____

By: _____

Contract Control Number: CSAHR-202263753-01
Contractor Name: KAISER FOUNDATION HEALTH PLAN OF COLORADO

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

Sarah Allen
Name: _____
(please print)

MSBD, VP
Title: _____
(please print)

ATTEST: [if required]

By: _____

Name: _____
(please print)

Title: _____
(please print)

EXHIBIT A-2

TO

AGREEMENT BETWEEN

CITY & COUNTY OF DENVER and

KAISER PERMANENTE INSURANCE COMPANY

Exhibit A-2 Summary of Benefits and Coverage (SBC) & EOC Amendment Inserts

1. SBC - City and County of Denver DHMO 500 20%
   Covered Services Coverage Period: 01/01/2025-12/31/2025

2. SBC - City and County of Denver HDHP 1650 AGG 20%.
   Covered Services Coverage Period: 01/01/2025-12/31/2025

3. SBC - Denver Police Department DHMO 500 20%
   Covered Services Coverage Period: 01/01/2025-12/31/2025

4. SBC - Denver Police Department HDHP 1600 AGG 20%.
   Covered Services Coverage Period: 01/01/2025-12/31/2025

5. EOC - City and County of Denver Insert 2025

6. EOC - Denver Police Department Insert Non-Medicare 2025

7. EOC - Denver Police Department Insert Medicare 2025

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

Coverage Period: 01/01/2025-12/31/2025

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

Coverage for: Individual / Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-855-249-5005 (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 Individual / $1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,500 Individual / $9,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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

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

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

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

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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care (20 visit limit/year)	• Hearing aids (Adult: $1,000 limit/ear, every 36 months; Up to age 18: 1 aid / ear / 60 months) • Infertility treatment	• Private-duty nursing • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

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

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

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:

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

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other copayment	**$0**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	**$500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other copayment	**$0**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	**$500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other copayment	**$0**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

Colorado Supplement to the Summary of Benefits and Coverage Form

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

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.

7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

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

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

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

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

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Bàsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700** （TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**)번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

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

Coverage Period: 01/01/2025-12/31/2025

KAISER PERMANENTE® : **City and County of Denver HDHP 1650 AGG 20%**

Coverage for: Individual / Family | Plan Type: HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-855-249-5005 (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,650 Individual / $3,300 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,300 Individual / $6,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

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

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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

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

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

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **$3,300**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,300
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,170**

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,650
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,250**

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,650
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**

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

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	City and County of Denver HDHP 1650 AGG 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available **only** in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld ***KP Select Plan:*** *El Paso and Teller*

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

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

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

USING THE PLAN

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

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HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Bàsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700** （TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**)번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

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

Coverage Period: 01/01/2025-12/31/2025

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

Coverage for: Individual / Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-855-249-5005 (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$500 Individual / $1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$4,500 Individual / $9,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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

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

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

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

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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care (20 visit limit/year)	• Hearing aids (Adult: $1,000 limit/ear, every 36 months; Up to age 18: 1 aid / ear / 60 months) • Infertility treatment	• Private-duty nursing • Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

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

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

Does this plan provide Minimum Essential Coverage? **Yes.**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

Language Access Services:

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

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

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

The plan's overall deductible	**$500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other copayment	**$0**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$2,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	**$500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other copayment	**$0**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,000**

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

The plan's overall deductible	**$500**
Specialist copayment	**$75**
Hospital (facility) coinsurance	**20%**
Other copayment	**$0**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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

Colorado Supplement to the Summary of Benefits and Coverage Form

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

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY – The maximum amount that the family will pay for the year. The family deductible can be met by [2] or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL – The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY – The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, coinsurance and copayments.

7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	Breast Cancer (clinical breast exam, screening and/or imaging, genetic testing for inherited susceptibility for breast cancer); Colon and Rectal Cancer (fecal occult blood test (FIT), flexible sigmoidoscopy, barium enema, colonoscopy); Cervical Cancer (Pap test); Prostate Cancer (digital rectal exam, serum prostatic specific antigen (PSA))

USING THE PLAN

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

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

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

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

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Bàsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700** （TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**)번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

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

Coverage Period: 01/01/2025-12/31/2025

KAISER PERMANENTE® : **Denver Police Department HDHP 1600 AGG 20%**

Coverage for: Individual / Family | Plan Type: HDHP

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see https://kp.org/plandocuments or call 1-855-249-5005 (TTY:711). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-249-5005 (TTY:711) to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$1,650 Individual / $3,300 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and services indicated in chart starting on page 2.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,300 Individual / $6,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.kp.org or call 1-855-249-5005 (TTY: 711) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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

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

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

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

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

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

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

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

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

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

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

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

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

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

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

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

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

About these Coverage Examples:

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

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

- **The plan's overall deductible** **$3,300**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,300
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,170**

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,650
Copayments	$400
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,250**

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

- **The plan's overall deductible** **$1,650**
- **Specialist coinsurance** **20%**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,650
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,860**

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

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Kaiser Foundation Health Plan of Colorado
NAME OF PLAN	Denver Police Department HDHP 1600 AGG 20%
1. Type of Policy	Large Employer Group Policy
2. Type of plan	Health maintenance organization (HMO)
3. Areas of Colorado where plan is available.	Plan is available **only** in the following counties: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Park, Pueblo, Teller, and Weld ***KP Select Plan:*** *El Paso and Teller*

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

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

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

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

USING THE PLAN

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

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

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

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

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

NONDISCRIMINATION NOTICE

Kaiser Foundation Health Plan of Colorado (Kaiser Health Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

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

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

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by mail at: Customer Experience Department, Attn: Kaiser Permanente Civil Rights Coordinator, 10350 E. Dakota Ave, Denver, CO 80247, or by phone at Member Services **1-800-632-9700** (TTY **711**).

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

HELP IN YOUR LANGUAGE

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

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ **1-800-632-9700** (TTY **711**).

العربية (Arabic) ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-632-9700** (TTY: **711**).

Bàsɔ̀ɔ̀ Wùɖù (Bassa) Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Đá **1-800-632-9700** (TTY **711**)

中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-632-9700** （TTY **711**）。

فارسی (Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-632-9700** (TTY **711**) تماس بگیرید.

Français (French) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-632-9700** (TTY **711**).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-800-632-9700** (TTY **711**).

Igbo (Igbo) NRỤBAMA: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-800-632-9700** (TTY **711**).

日本語 (Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-632-9700**（TTY **711**）まで、お電話にてご連絡ください。

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-800-632-9700** (TTY **711**)번으로 전화해 주십시오.

Naabeehó (Navajo) Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih **1-800-632-9700** (TTY **711**).

नेपाली (Nepali) ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । **1-800-632-9700** (TTY: **711**) फोन गर्नुहोस् ।

Afaan Oromoo (Oromo) XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-800-632-9700** (TTY **711**).

Русский (Russian) ВНИМАНИЕ: если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-632-9700** (TTY **711**).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-632-9700** (TTY **711**).

Tagalog (Tagalog) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-632-9700** (TTY **711**).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-632-9700** (TTY **711**).

Yorùbá (Yoruba) AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi **1-800-632-9700** (TTY **711**).

CITY AND COUNTY OF DENVER
EVIDENCE OF COVERAGE AMENDMENT - 2025

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

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean: career service employees as defined in section 9.1.1(e) of the charter, appointed charter officers as defined in section 9.2.1(B) of the charter, and elected charter officers as defined in section 9.2.1 (A) of the charter. The definition of eligible employee shall not include:
   a) Part-time employees who are regularly scheduled to work less than twenty (20) hours per week;
   b) Members of the classified service of the police and fire departments; and,
   c) Persons occupying or employed in on-call (Eligible if employed for 12 months and averaging at least 30 hours per week in accordance with the Patient Protection and Affordable Care Act), temporary, seasonal, or contract positions, or positions in which the incumbent is paid according to the community rate schedule.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse or a spousal equivalent.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse through marriage or common-law.

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

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

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

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

DENVER POLICE DEPARTMENT
NON-MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2025

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

1) "Child" shall mean a primary insured's natural child, adopted child, or the natural child or adopted child of either a primary insured's spouse, or primary insured's partner in a civil union.

2) "Eligible dependent" shall mean the primary insured's child or spouse
   a) An eligible dependent may not also be a primary insured on the same insurance plan.
   b) If spouses are each eligible employees, each may enroll in medical or dental coverage as either a primary insured or eligible dependent, but not both.
   c) An eligible dependent shall not include any form of grandchild of a primary insured or spouse, unless the primary insured or spouse has a court order of adoption.
   d) An eligible dependent may be covered by one (1) primary insured only for each insurance plan.

3) "Eligible employee" shall mean:
   a) Members of the classified service of the police department.

4) "Employee only" coverage shall mean insurance coverage for an eligible employee only.

5) "Employee plus children" coverage shall mean insurance coverage for an eligible employee and one (1) or more eligible dependents other than a spouse.

6) "Employee plus spouse" coverage shall mean insurance coverage for an eligible employee and a spouse or a spousal equivalent.

7) "Employer contribution" shall mean funds paid by the city for insurance programs approved by the employee health insurance committee.

8) "Family" coverage shall mean insurance coverage for an eligible employee and a spouse or spousal equivalent and one (1) or more other eligible dependent.

9) "Primary insured" shall mean an eligible employee who enrolls for insurance coverage.
   a) A primary insured may not also be an eligible dependent on the same insurance.

10) "Spouse" shall mean an eligible employee's lawful spouse, through marriage or common-law.

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

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

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

DENVER POLICE DEPARTMENT
MEDICARE EMPLOYEES

EVIDENCE OF COVERAGE AMENDMENT - 2025

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

ELIGIBILITY AND ENROLLMENT

Eligible Dependents

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

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

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

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

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

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

Eligibility Rules: No waiting period

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

EXHIBIT A-3

TO

AGREEMENT BETWEEN

CITY & COUNTY OF DENVER and

KAISER PERMANENTE INSURANCE COMPANY

Exhibit A-3 Performance Metrics

1. 2025 Performance Guarantees – City and County of Denver
2. 2025 Performance Guarantees – Denver Police

KAISER PERMANENTE®

2025 Performance Guarantees Agreement

City and County of Denver

Guaranteed Performance

This Performance Guarantees Agreement is effective from January 1, 2025 through December 31, 2025.

We offer performance guarantees for our fully insured health plans backed by a percentage of your annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of your non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of your non-Medicare members will report performance without financial risk. In 2026, we will conduct a review of your 2025 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures

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

Penalty Thresholds and Reporting Frequency

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. Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential

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

Penalty Payments and Force Majeure

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 the group's total non-Medicare premium for the calendar year. We pay agreed-upon penalties by Automated Clearing House (ACH). The group is responsible for notifying their account management team of the correct banking information to which payment should be sent when processed.

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

If we are unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2025, in order to receive any penalty payments for missed performance measures due under this agreement. We require that Customer dispute any performance results and/or penalty due by submitting written notice to us within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser Permanente of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Your written response must be received within 60 days of your receipt of our final report or you will forfeit any penalties otherwise due to you under this agreement.

Account Management Measures

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

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

To contact Kaiser Permanente

Thank you for giving 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®

2025 Performance Guarantees Agreement

City and County of Denver

Based on projected 2025 membership, we expect the **City and County of Denver** healthplan will be guaranteed with premium at risk.

This Performance Guarantees Agreement is effective from January 1, 2025 through December 31, 2025.

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

2025 Performance Measures		Penalty Threshold	Penalty (% of Premium)
Member Services			
1	**City and County of Denver** - Eligibility information available to medical groups within 8 business days (% of PG groups)	95%	0.06%
2	Average Speed to Live Voice	30 sec	0.06%
3	Telephone call abandonment rate	≤ 3.0%	0.06%
4	First contact resolution (includes emails, same member / same issue call back within 30 days)	80%	0.06%
5	KP.org web site availability (for non-secure sections, and excluding scheduled maintenance and downtime) - Kaiser national performance	98.5%	0.06%
Member Satisfaction			
5	Member satisfaction with health plan (CAHPS #31)[1]	≥ State Avg.[2]*	0.08%
Account Management			
7	Customer overall satisfaction with account management/team	Satisfied	0.10%
8	AM/team availability for periodic meetings and open enrollment (2-4 per year)	Meet	0.10%
8	AM/team response to client calls – within one business day	Meet	0.10%
Claims			
7	Claims Financial Accuracy	98.5%	0.08%
8	Claims Processing (financial incident) Accuracy	97%	0.08%
8	Claims Processing w/in 30 Calendar Days (clean claims)	95%	0.08%
Quality of Care			
9	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	≥ Natl. Avg.[3]*	0.10%
10	Cervical Cancer Screening Rate	≥ Natl. Avg.[3]*	0.10%
11	Colorectal Cancer Screening Rate	≥ Natl. Avg.[3]*	0.10%
12	Controlling High Blood Pressure – Total	≥ Natl. Avg.[3]*	0.10%
13	Asthma Medication Ratio	≥ Natl. Avg.[3]*	0.10%
14	Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy (Total)	≥ Natl. Avg.[3]*	0.10%
15	Eye Exam for Patients with Diabetes	≥ Natl. Avg.[3]*	0.10%
16	Blood Pressure Control for Patients with Diabetes	≥ Natl. Avg.[3]*	0.10%
17	Glycemic Status Assessment for Patients With Diabetes – poor control >9%	≤ Natl. Avg.[3]*	0.10%
18	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. Avg.[3]*	0.10%
19	Prenatal Care Rate	≥ Natl. Avg.[3]*	0.10%
20	Postpartum Care Rate	≥ Natl. Avg.[3]*	0.10%
Accreditation and Reporting			
21	NCQA Accreditation	Maintain	0.09%
22	HEDIS report available – within one month after NCQA public release of results	Report Available	0.09%
Total Percent at Risk			**2.00%**

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

[2] Based on NCQA's State/Regional HMO Average

[3] Based on NCQA's National HMO Average

* Penalties are contingent on statistically significant differences from targets

KAISER PERMANENTE®

2025 Performance Guarantees Agreement

Denver Police

Guaranteed Performance

This Performance Guarantees Agreement is effective from January 1, 2025 through December 31, 2025.

We offer performance guarantees for our fully insured health plans backed by a percentage of your annual non-Medicare premium for Kaiser Permanente plans that have 500 or more of your non-Medicare members. Once one plan qualifies for an at-risk guarantee, other Kaiser Permanente plans with at least 100 but fewer than 500 of your non-Medicare members will report performance without financial risk. In 2026, we will conduct a review of your 2025 membership (average over 12 months) to determine the appropriate status of this agreement in each plan.

Changes in Measures

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

Penalty Thresholds and Reporting Frequency

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. Typically, in the fall of each year (after the annual release of HEDIS results) we provide an annual performance report for the preceding year. Performance guarantees require annual renewal and must be requested each year by the Customer.

Proprietary and Confidential

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

Penalty Payments and Force Majeure

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 the group's total non-Medicare premium for the calendar year. We pay agreed-upon penalties by Automated Clearing House (ACH). The group is responsible for notifying their account management team of the correct banking information to which payment should be sent when processed.

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

If we are unable to provide any of the information guaranteed in this agreement due to force majeure or federal, state or local legislative or regulatory action, the measures affected by such action will not be subject to penalties. Customer must be currently enrolled, and its account in good standing, at the end of the reporting period, December 31, 2025, in order to receive any penalty payments for missed performance measures due under this agreement. We require that Customer dispute any performance results and/or penalty due by submitting written notice to us within 60 days after the date the final report is delivered, or payment is made. Unless Customer notifies Kaiser Permanente of a dispute within such 60-day period, the report and penalty payment, if applicable, shall be considered final and not subject to dispute. Your written response must be received within 60 days of your receipt of our final report or you will forfeit any penalties otherwise due to you under this agreement.

Account Management Measures

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

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

To contact Kaiser Permanente

Thank you for giving 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®

2025 Performance Guarantees Agreement

Denver Police

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

This Performance Guarantees Agreement is effective from January 1, 2025 through December 31, 2025.

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

	2025 Performance Measures	Penalty Threshold	Penalty (% of Premium)
Member Services			
1	Member service calls - percent answered within 30 seconds	80%	0.08%
2	Telephone call abandonment rate	≤ 3.0%	0.06%
3	Call Quality	85%	0.06%
4	Eligibility information available to medical groups within 8 business days (% of PG groups)	95%	0.06%
5	Premium/Eligibility reconciliation within 30 calendar days (% of PG groups)[1]	85%	0.06%
6	KP.org web site availability (for non-secure sections, and excluding scheduled maintenance and downtime) - Kaiser national performance	98.5%	0.06%
Member Satisfaction			
7	Member satisfaction with health plan (CAHPS #31)[2]	≥ State Avg.[3]*	0.06%
Account Management			
8	Customer overall satisfaction with account management/team	Satisfied	0.10%
9	AM/team availability for periodic meetings and open enrollment (2-4 per year)	Meet	0.10%
10	AM/team response to client calls – within one business day	Meet	0.10%
Quality of Care			
11	Weight Assessment & Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	≥ Natl. Avg.[4]*	0.09%
12	Cervical Cancer Screening Rate	≥ Natl. Avg.[4]*	0.09%
13	Colorectal Cancer Screening Rate	≥ Natl. Avg.[4]*	0.09%
14	Controlling High Blood Pressure – Total	≥ Natl. Avg.[4]*	0.09%
15	Asthma Medication Ratio	≥ Natl. Avg.[4]*	0.09%
16	Statin Therapy for Patients with Cardiovascular Disease Received Statin Therapy (Total)	≥ Natl. Avg.[4]*	0.09%
17	Eye Exam for Patients with Diabetes	≥ Natl. Avg.[4]*	0.09%
18	Blood Pressure Control for Patients with Diabetes	≥ Natl. Avg.[4]*	0.09%
19	Glycemic Status Assessment for Patients With Diabetes – poor control >9%	≥ Natl. Avg.[4]*	0.09%
20	Follow-up After Hospitalization for Mental Illness (30 days)	≥ Natl. Avg.[4]*	0.09%
21	Prenatal Care Rate	≥ Natl. Avg.[4]*	0.09%
22	Postpartum Care Rate	≥ Natl. Avg.[4]*	0.09%
Accreditation and Reporting			
23	NCQA Accreditation	Maintain	0.09%
24	HEDIS report available – within one month after NCQA public release of results	Report Available	0.09%
Total Percent at Risk			**2.00%**

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

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

[3] Based on NCQA's State/Regional HMO Average

[4] Based on NCQA's National HMO Average

* Penalties are contingent on statistically significant differences from targets