KAISER FOUNDATION HEALTH PLAN OF COLORADO

2023 Access Plan

Colorado Service Area (KPIF, Small Group, and Colorado Option Standardized Plans)

Contents

1. INTRODUCTION

Carrier Name: Kaiser Foundation Health Plan (KFHP) of Colorado
Full Name of Network: Kaiser Permanente Colorado (KPIF, Small Group, and Colorado Option Standardized Plans)
Carrier Network ID Number: CON001 & CON003

Kaiser Foundation Health Plan (KFHP) of Colorado is the largest nonprofit health plan in the state. It is part of an integrated health care delivery network, Kaiser Permanente, that includes Kaiser Foundation Health Plan (KFHP) of Colorado and the Colorado Permanente Medical Group (CPMG). Kaiser Permanente provides comprehensive health care services to its members through CPMG physicians and a network of physicians and other providers that contract directly with CPMG and KFHP of Colorado.

The Kaiser Permanente website, **kp.org**, provides a list of plan providers, their locations, and their specialties. Members may also request a list of providers and facilities by calling Member Services at 303-338-3800 or 1-800-632-9700 (TTY 711), Monday through Friday, from 8 a.m. to 6 p.m.

Members are able to access CPMG primary and specialty care services at Kaiser Permanente Medical Offices. Members may make appointments at **kp.org** or by calling the Clinical Contact Center at 303-338-4545 or 1-800-281-1059 (TTY 711), Monday through Friday, from 6 a.m. to 7 p.m. Members may call that same number for medical advice. Members may also find affiliated network providers in the provider directory at **kp.org**. Kaiser Permanente also has contracted urgent and emergency care locations across the service area. Members may find a list of urgent and emergency care locations at **kp.org**.

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Colorado service area
Kaiser Permanente's Colorado network (which is also offered as a Colorado Option Standardized plan) serves the following counties: Boulder, Broomfield, Denver, Douglas, Gilpin, Jefferson, Larimer, Pueblo, Teller, and Weld as well as portions of Adams, Arapahoe, Clear Creek, Crowley, Custer, El Paso, Elbert, Fremont, Huerfano, Las Animas, Lincoln, Morgan, Otero, and Park counties.

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESS

A. Summary

Kaiser Permanente has standards for provider-to-member ratios, geographic accessibility, and appointment wait times that comply with Colorado Division of Insurance (DOI) regulation. Kaiser Permanente quarterly undertakes "geoaccess" reporting to assure that both the number of physicians and their geographic availability are within established standards. Network adequacy geographic accessibility for Kaiser Permanente's membership is determined by their driving

distance to the nearest primary care, specialty care, and facility providers. Geographic membership trends and internal and external market analysis allow Kaiser Permanente to adjust the number of physicians and locations in order to accommodate the needs of its members.

Kaiser Permanente meets geographic access, provider-to-enrollee ratio, and appointment wait time requirements as described below:

Appointment Wait Time Standards:
Kaiser Permanente meets Appointment Wait Time standards for Emergency Care, Urgent Care, Primary Care (including after-hours), Prenatal Care, Preventive/Well Visits, and non-urgent Specialty Care.

Kaiser Permanente is not meeting the prescribed appointment wait times for routine, non-urgent Behavioral Health and Mental Health. Please see the Corrective Action Process section for more information on how KP is working to improve access in this area.

Provider-to-Enrollee Ratios:
Kaiser Permanente meets all Provider-to-Enrollee Ratio requirements.

Geographic Access Standards:
Kaiser Permanente meets all Geographic Access standards, except for Certified Nurse Midwives as required for Colorado Option standardized plans. Please see the Corrective Action Process section for more information on how KP is working to improve access in this area.

Kaiser Foundation Health Plan of Colorado has contracted with the Colorado Permanente Medical Group as well as numerous affiliate providers in the community to ensure that members have access to all services as appropriate.

B. Monitoring the Sufficiency of the Network

KPCO utilizes a documented process for measuring the sufficiency of our network to meet the healthcare needs of our enrollees. As part of this process, Kaiser Permanente conducts ongoing network adequacy monitoring to ensure that current and potential membership population will have adequate access to provider and facility types including Hospitals, as stated in DOI regulation.

Our contracts with providers require them to notify us of any adds/changes/deletions to their provider profile as they occur. We also identify the expectations we have for reasonable accessibility and we have a communication process with the providers to ensure that any changes in availability or composition of their practices are documented. Kaiser Permanente performs a quarterly outreach to its entire provider network in order for them to attest to the accuracy of their provider group profile that is on record in the provider database that feeds to the online directory, **kp.org**. Our enrollees have online or telephonic tools to communicate any concerns they may experience in obtaining necessary health care services. At any time in any specialty where appropriate access is questioned, we will research the concern and remediate, if appropriate, to address the concern.

Telehealth Services:
All CPMG physicians in primary care and all specialties who provide scheduled outpatient care are able to provide medically appropriate care by video. Many of our network providers are also able to provide care virtually when medically appropriate. Kaiser Permanente has documented how the use of telemedicine or telehealth or other technology may be used to meet member care needs.

C. Factors Used to Build the Provider Network

Kaiser Permanente considers the following factors/criteria as it builds and maintains provider networks:

- Size and demographics of the population to be served;
- The inventory of provider types required to serve the population and using practitioner to member ratios and geographic access standards metrics to ensure adequacy;
- Application of rigorous credentialing criteria encompassing but not limited to educational training, licensing, professional experience, board certification, and professional references.

The Colorado network features a mixture of CPMG physicians and community providers that deliver primary care and specialty care. Prevalence of community providers depends on service area needs and what is required in order to meet geographic accessibility requirements for its membership. The Colorado network is supplemented with a high volume of contracted providers in the Northern and Southern parts of the region.

Provider Tiering
Only primary care providers are tiered. For purposes of tiering, Primary Care refers to only Internal Medicine, Family Medicine and Pediatric providers. Primary care providers who are employed by the Colorado Permanente Medical Group are in a tier with a lower cost share than primary care providers who are contracted with Colorado Permanente Medical Group. This is the only criteria applied to tier providers in the network. Tiering does not apply to mental health providers, OB/GYN providers, or other specialties.

D. Community Health Workers

KPCO employs seven "community specialists" who help patients with non-medical concerns by connecting them with community agencies that specialize in addressing social and economic needs such as rent and utility assistance, food assistance, transportation, parenting resources, legal assistance, and much more. Any member may contact their care team's community specialist by calling (303) 614-1138. Members may also visit **kp.org/socialhealth** for a directory of nearby organizations and services available to them or call 1-800-443-6328.

E. Option Plan Network Development

The Colorado Option plan utilizes the same network of providers as our regular Colorado commercial network. In order to create a more culturally responsive network, KPCO is working to add numerous new Essential Community Providers and Certified Nurse Midwives to the network.

F. Obtaining Covered Benefits if Network is Not Sufficient

Refer to "Procedures for Referrals" section of this Access Plan.
Kaiser Permanente provides services to our members using Colorado Permanente Medical Group (CPMG) physicians and network providers. If there are services that are not available within CPMG or the network, Kaiser Permanente will provide authorizations and coverage at the in-network benefit level to qualified external providers for the service that is not available. Kaiser Permanente will utilize local providers when possible, or out-of-state specialists, if necessary.

Kaiser Permanente ensures through its review of out-of-network authorization requests, and its establishment of a single case rate agreements for providers outside of the network, that the cost shall not exceed the cost of the same and or equal service to providers in-network.

G. Monitoring Access to Physician Specialist Services

Kaiser Permanente has processes for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at our contracted hospitals.

Refer further to the process outlined in "Monitoring the Sufficiency of Network" section.

H. Assessing the Network for Anticipated Demand

KPCO strives to create a network that is culturally responsive and one which is adequate to meet the needs of our members by performing numerous ongoing activities, including: combining relative access metrics to predict anticipated demand, observing the current utilization of services, and monitoring the access outcomes. When internal services cannot meet the anticipated demand, the organization has developed, and continues to develop, a broad network of external providers that can be accessed to meet the anticipated demand and supplement access to specific areas of the network.

I. Quality Assurance

Quality and Health Improvement Committee (QHIC)
The Board of Directors oversees quality through the national Quality and Health Improvement Committee (QHIC). The QHIC consists of three or more Directors, who are selected by the Board and who serve as members of the QHIC at the pleasure of the Board. The QHIC meets at least four times per year and reports its decisions, actions, and recommendations to the Board. Staff support is provided by the National Health Plan and Hospitals Quality Department.

The Quality and Health Improvement Committee (QHIC) provides:

- Strategic direction for quality assurance and improvement systems.
- Oversight of systems designed to ensure that quality care and services are provided at a comparable level to all members and patients throughout the Program and across the continuum of care.
- Oversight of the Program's quality assurance, improvement systems and organizational accreditation and credentialing.

Kaiser Permanente National Quality Committee (KPNQC)
The mission of the Kaiser Permanente National Quality Committee (KPNQC) is to establish, guide, and support the National Clinical Quality Strategy, which will set uniform measures and targets, eliminate unwarranted variation, spread successful practices, and facilitate the delivery of safe, timely, effective, equitable, efficient and patient-centered clinical care by the Kaiser Permanente Medical Care Program, in furtherance of the Quality Programs, developed collaboratively with Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and the Permanente Medical Groups.

KPNQC is accountable to and acts at the direction of QHIC. As part of its oversight responsibilities, KPNQC reviews annual program descriptions, work plans and evaluations, as well as quality reports and minutes from each region. KPNQC meets no fewer than four (4) times per year and is a peer review body.

Kaiser Permanente Colorado Quality Oversight Committee (QOC)
The Quality Oversight Committee (QOC) supports Kaiser Permanente by providing oversight and evaluation of the effectiveness of all aspects of the Quality Program, including clinical quality, access to services, service quality, and safety. It is co-chaired by KFHP's Vice President for Quality Safety, Strategy & Acceleration, Research and by CPMG's Vice President and Chief Quality Officer. At least 51% of the QOC's membership is comprised of physicians. Other members include clinical and quality leaders. The QOC reports its activities and functions to the KFHP Board of Directors through QHIC.

The purpose of the QOC is to:

- Recommend quality strategies in alignment with National and Regional strategic priorities, mission, and vision;
- Oversee and evaluate quality assessment and improvement activities throughout the Region;
- Be accountable to the KFHP Quality Health Improvement Committee (QHIC) for safety and quality of clinical care and services.

QOC Subcommittees
The QOC assigns certain responsibilities to subcommittees that are required to report to QOC at least three times a year, or more often if necessary. The charters for each subcommittee are updated annually and include expectations, authority/scope, and membership. QOC membership and subcommittee membership is reviewed annually. The subcommittees of the QOC are:

- Access Quality Oversight Committee (AOC)
- Behavioral Health Quality Oversight Committee (BHOC)
- Continuum of Care Quality Oversight Committee (CCOC)
- Credentialing/Privileging Committee (CPC)
- Integrated Safety Quality Oversight Committee (ISOC)
- Member Concerns Quality Oversight Committee (MCOC)
- Regional Services Quality Oversight Committee (RSOC)

J. Corrective Action Process

If, as a result, of Kaiser Permanente's ongoing network adequacy monitoring, a deficiency or gap

in network adequacy is found for members in a service area, the organization will work with the clinical operations teams and the Colorado Permanente Medical Group leadership teams to determine whether the deficiency can be filled with the integrated delivery model by providing additional staffing at a Kaiser Medical Office location. If the addition of a provider through the integrated delivery model of Kaiser Permanente is not feasible, leadership from the Provider Contracting teams will be notified to identify if the gap can be closed through contracting with a network provider. The network provider that is identified to close the network adequacy gap will be expected to meet a set of standards to provide capacity to its membership as would be expected in the integrated delivery model. An extensive credentialing process occurs to ensure quality healthcare delivery to the member population.

If no such provider exists that can fill the gap, Kaiser Permanente will employ remote health methodology including but not limited to the use of telehealth medicine and mail order pharmacy to provide sufficient medical care needs to its membership population. Such deficiencies will be reported to the DOI in the annual binder filing if no remedy can be employed to close the network adequacy gap.

Access Improvement Plans

Kaiser Permanente Behavioral Health is currently unable to meet the appointment access requirements set forth by the Colorado DOI due to the ongoing increased demand for routine Behavioral Health care alongside ongoing workforce issues. In order to improve access, Kaiser Permanente has implemented the following strategies:

- Implementation of ongoing, partial work from home options for therapists and psychiatrists to improve recruitment and retention
- Increase access in addiction services by further increasing appointments and reducing appointment loss due to no shows
- KP National support for additional recruitment and retention efforts in support of BH professional staffing
- Continued expansion of the KPCO affiliate network of providers with steady additions of local provider groups throughout the year as well as the addition of a National group, Amwell Therapy in Q4 of 2021. Current RFP process to assess additional National groups.

KP is also offering additional technology solutions to assist members in managing their mental health, including Ginger Coaching, Calm, While, Silvercloud, Thrive and myStrength apps.

The Beacon Health Options provider network does not meet the appointment access requirements set forth by Colorado DOI. To remediate this, Beacon will perform the following activities:

- Continuing recruitment efforts to include more providers to increase capacity of network
- Increase utilization of referrals to telehealth providers when medically appropriate
- Work with providers who are not meeting appointment access to update availability in Beacon's system

Kaiser Permanente does not currently meet geographic access standards for Certified Nurse Midwives as required for the Colorado Option Standardized plans. KP has attempted to contract with numerous midwifery practitioners across the service area and continues to seek contracts with any midwives that

are able to appropriately serve our members.

3. PROCEDURES FOR REFERRALS

A. Comprehensive Listing of Providers and Facilities

Kaiser Permanente's Provider Directory is available on **kp.org** and from Member Services and includes all of our network providers and facilities. The online directory is updated on a daily basis. The provider directory is also available in Spanish both online and in print.

B. Procedures for Referrals

1. **Referral Options** Referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services. Generally, you will need a referral and prior Authorization in order to receive services (including routine visits) from specialty-care Plan Providers. You do not need a referral or prior Authorization in order to obtain access to eye care services or OB/GYN care.
2. **Timely Referrals for Access to Specialty Care** Kaiser Permanente processes all referrals according to applicable State/Federal and NCQA timeline requirements and makes the determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after the receipt of the request. A one-time, 14 day extension may be granted if requested or if it is justified. Kaiser Permanente's "Timeliness of UM Decision Making Policy and Procedure" addresses the full process for referral timeliness requirements.
3. **Expedited Referral Process** Kaiser Permanente will make a decision as expeditiously as the member's health condition requires, but no later than 72 hours after the receipt of the request. Kaiser Permanente's "Timeliness of UM Decision Making Policy and Procedure" addresses the full process for urgent referrals.
4. **Approved Referrals Cannot be Retrospectively Denied** Referrals that have been approved cannot be retrospectively denied, except for fraud or abuse.
5. **Approved Referrals Cannot be Changed After Preauthorization** Referrals cannot be changed after preauthorization unless there is evidence of fraud or abuse.
6. **Disclosure of Variable Deductible, Coinsurance and/or Copayments** Only primary care providers are tiered. For purposes of tiering, Primary Care refers to only Internal Medicine, Family Medicine and Pediatric providers. Primary care providers who are employed by the Colorado Permanente Medical Group are in a tier with a lower cost share than primary care providers who are contracted with Colorado Permanente Medical Group. This is the only criteria applied to tier providers in the network. Tiering does not include mental health providers, OB/GYN providers, or other specialties.

C. Out-of-plan Referrals

If your plan provider decides that you need covered services that are not available from Kaiser Permanente, they will request a referral for you to see an Out-of-Plan Provider.

4. DISCLOSURES AND NOTICES

A. Method for Informing Covered Persons

Kaiser Permanente annually provides members with an Evidence of Coverage (EOC) summarizing the benefits and services available to each member. Coverage varies depending on the particular plan in which the member is enrolled. Members may view a copy of their EOC as a registered member at **kp.org/mydocuments**. Members may obtain a printed copy of the EOC by calling Member Services, **303-338-3800** or toll-free **1-800-632-9700**, weekdays, from 8 a.m. to 6 p.m. Deaf or hard of hearing people who use TTY may call **711**.

B. Required Disclosures:

The EOC includes the following information:

1. Grievance Procedures
   Information on Kaiser Permanente's appeals and complaints procedures and filing claims that is in conformance with the Division regulations.

2. Availability of Specialty Medical Services
   Information about the availability of specialty services, including behavioral health, physical therapy, occupational therapy and rehabilitative services**.**
3. Providing and Approving Emergency and Non-Emergency Medical Care
4. Process for Choosing and Changing Network Providers

Nondiscimination Notice:

5-7. Kaiser Permanente Colorado's 'Nondiscrimination and Help in your Language' notice contains information on how a member can obtain interpretation, translation, and other language assistance services (including ASL) at no additional cost to the member. This notice is contained within the Open Enrollment Guide and the New Member Guide (which are sent upon enrollment) as well as other marketing materials such as the Provider Directory and member benefit packages. It is also posted on **kp.org** and in all Kaiser Permanente Colorado Medical Office Buildings. Kaiser Permanente Colorado also provides a TTY number alongside all phone numbers in all member marketing materials. The Equity, Inclusion, and Diversity program described below details KPCO's processes for identifying the needs of special populations and eliminating health disparities for our members and communities.

Equity, Inclusion and Diversity

KFHP established the national diversity and inclusion function in 1997 to operationalize the company's diversity and inclusion strategy across the organization. In 2017 the name was changed to National Equity, Inclusion, and Diversity to reflect the increasing focus on equity for members, patients, employees, and communities. This department leads efforts to implement KP's equity, inclusion, and diversity strategy through the development of key initiatives and expert consultation throughout the enterprise.

In Colorado the team responsible to implement and guide the EID Strategy reports to the Vice President of Human Resources. The EID Team includes the Director of Performance Improvement, Learning & Organizational Effectiveness, and EI&D, the Senior Equity, Inclusion, and Diversity Program Manager, and the Workforce Diversity Consultant. The team is also supported by a Consulting Project Manager, Program Manager, and an HR Consultant.

Equity, Inclusion and Diversity (EID) councils exist at both the national and regional levels. They are responsible for engaging employees in EID initiatives and program and

are accountable for achieving diversity-related goals.

Regional Overview

The mission of the regional Colorado EID team is to focus on the elimination of health disparities of members and their communities by integrating diversity, equity and inclusion into all aspects of the organization by ensuring a diverse and culturally competent workforce. As part of this mission, Kaiser Permanente assesses cultural and linguistic needs and preferences of the member population and compares these against the current workforce and regional demographics.

Consistent with its mission, Kaiser Permanente Colorado oversees a comprehensive diversity strategic plan, developed and endorsed by the National Office of Equity, Inclusion and Diversity, focusing on integrating diversity and inclusion into all aspects of the organization. One of the main focus is to create an environment where all staff and members feel valued and respected.

KP will focus on the following objectives to achieve the above mission:

- Train all staff and physicians to Break Bias and Dismantle Racism through Belong@KP
- Identify barriers in the delivery of health care to diverse populations;
- Identify our member linguistic needs and cultural identity using member self-identification and compliance data;
- Prepare staff to provide ethnically, racially, culturally and linguistically appropriate medical care and services to improve the health and satisfaction of our increasingly diverse membership;
- Enhance the diversity, cultural competence, skills and performance of our workforce;
- Identify bilingual providers within each service area;
- Evaluate, track and document best practices, and share them with other KP regions;
- Support membership growth through ensuring we have a diverse workforce aligned with specific populations that are emerging segments of society; and,
- Focus on workforce equity in partnership with the National Office of Equity, Inclusion and Diversity (EID).

8. Assessing Health Care Needs and Evaluating Member Satisfaction

The **kp.org** website includes information on the following:

- Kaiser Permanente, in partnership with Rally Health, offers a health risk assessment branded as the Total Health Assessment (THA) and 9 Healthy Lifestyle Programs (HLPs) to all members registered on **kp.org**. The THA and HLPs are evidence-based behavior change programs that engage participants in understanding their health status and support behavior change. The THA is Kaiser Permanente's health risk appraisal tool where members complete a detailed online questionnaire to assess demographics, health goals, interests, motivations, and barriers to healthy living. To access the THA, members visit Kaiser Permanente's website at **kp.org/tha**. Based on the responses, participants receive

health activities they can do in their daily lives, tips on how to stay aware of their habits and make changes that last and tools and resources to help jumpstart their wellness journeys, including online HLPs.

The following are some features of the THA program:

- Members complete an online questionnaire that asks some simple questions about their health and medical history. The questionnaire includes questions about diet, exercise habits, weight and other habits and behaviors that affect health.
- Based on answers to the questionnaire, members receive a personalized health summary to help them set and reach their health goals.
- The responses are strictly confidential. Members' answers will not affect their health benefits from Kaiser Permanente in any way.

The THA is designed to educate and motivate members to improve their health and helps members target specific programs that help meet their health needs.

Kaiser Permanente's website also offers members access to interactive online health tools and calculators to help members manage their weight, lower stress, quit smoking and become more fit. In addition, **kp.org** enables members to look up information on drugs or medical conditions, request or reorder health ID cards, check the facility or medical staff directory and view, print and/or download the *Member Resource Guide*, a reference guide to Kaiser Permanente services.

In addition to the THA, Kaiser Permanente has developed a state-of-the-art health maintenance appointment, based on recommendations from the U.S. Preventive Services Task Force, the American Heart Association, the American Cancer Society, the American College of Obstetrics and Gynecology and the American Medical Association. Kaiser Permanente health maintenance appointments are:

- Age-specific
- Emphasize member's individual health history and personal habits
- Include tests and procedures for those at risk for developing a disease due to personal habits or family history

Member Satisfaction

Kaiser Permanente uses several methods to inquire of members how satisfied they are with the services received. On an ongoing basis, information is gathered from satisfaction surveys, including the Member Experience Tracking Evaluation and Opinion Research Survey (METEOR), Patient Satisfaction Survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), Art of Medicine, reviews posted publicly on the web, and the review and evaluation of complaints and appeals.

Survey feedback is collected through three methods, depending on the survey. CAHPS and METOER surveys are the most robust using mail, phone and web-based surveys. The Patient Survey and the Art of Medicine primarily use web with phone outreach to supplement areas where KPCO does not have an email address for the member or to follow-up with those members who have not responded to the email invitation.

Both the CAHPS and METEOR Surveys assess the members' experiences with both health care received, customer service within the health plan and information about plan and benefits. The Patient and Art of Medicine surveys follow a specific visit and focuses on member's satisfaction with their visit including appointment access satisfaction and scheduling; physician's manner, attitude; overall visit satisfaction; and coordination of care. Physicians take these evaluations very seriously. If the rating is poor, the physician is counseled and goals are set for improvement.

5. PLAN FOR COORDINATION AND CONTINUITY OF CARE

A & B. Coordination and Continuity of Care for Specialty and Ancillary Services

Kaiser Permanente follows the Transition to Other Care and Authorization of Service Policies when assisting members with coordination and continuity of care within the Utilization Management department, along with coordination with the Care Continuum Population Health team for additional support and resources within the community.

The Utilization Management Professionals (UMPs) review approved clinical and medical and behavioral health criteria based on member needs, along with consulting the UM Physicians when applicable, to ensure our members are at the right level of care, at the right time, and in the right place.

Our member-centered approach ensures that member access to care is evaluated and determined by member individual needs, whether that be within the network of contracted providers or non-contracted providers for continuity of care to ensure our members are reaching their optimal function.

Services coordinated by the Population Health team include (but are not limited to): palliative services, ancillary community providers, complex case management, visiting nurses, care giver support, Meals on Wheels, clinical and behavioral health education, and transition of care management. These activities are completed with every high-risk member when the need arises.

C. Process for Ensuring Appropriate Discharge Planning

Members are informed about care alternatives during hospitalization as part of the hospital discharge planning process. Additionally, Kaiser Permanente partners with hospital case managers to assist with discharge needs.

Kaiser Permanente monitors all discharges via automatic notification through our electronic medical record. This allows for identification and stratification of discharging members to ensure appropriate follow up. Members are outreached by the Transitions Team, consisting of MAs and RNs, telephonically to assess needs, perform medication reconciliation and determine follow up needs. Follow up includes visits with primary care physicians, specialists, or in-home visit from an Advance Practice Nurse.

D. Process for Covered Persons to Choose and Change Primary Care Provider

Your Primary Care Provider

Your primary care provider (PCP) plays an important role in coordinating your health care needs. This includes hospital stays and referrals to specialists. Every member of your family should have their own PCP.

Choosing Your Primary Care Provider

You may select a PCP from family medicine, pediatrics, or internal medicine. When possible, we encourage you to choose a PCP whose office is in a Kaiser Permanente Medical Office Building. You may have a higher Copayment and/or Coinsurance with certain providers. Please refer to your Schedule of Benefits for additional details.

a. You must choose a PCP when you enroll. If you do not select a PCP upon enrollment, one near your home will be assigned to you. To review a list of Plan Providers and their biographies, go to **kp.org/locations**. You can also get a copy of the directory by calling Member Services. To choose a PCP, sign into your account online, or call the Clinical Contact Center for help choosing a PCP.

Changing Your Primary Care Provider

Please call the Clinical Contact Center to change your PCP. You may also change your PCP online or when visiting a Medical Office Building. You may change your PCP at any time.

E. Process for Providing Continuity of Care in the Event of a Contract Termination

In the event that Kaiser Permanente discontinues service in any region, arrangements will be made, in compliance with state and federal requirements, to transfer operations to another organization with no disruption in services. Members will be advised of this action well in advance. Kaiser Permanente makes a good faith effort to provide timely written notification to health plan members affected by the termination of a practitioner or practice site. Members who are affected by changes in the practice of a PCP, specialty care practitioner or practice site resulting from resignation, retirement, increased administrative responsibilities or transfer to another medical facility/office are **mailed a written letter within 15 to 30 days of the practitioner's formal notification** to the Health Plan/Medical Group of termination of employment/practice. This letter includes instructions on how to transfer your care to another provider. In addition, Kaiser Permanente has established a process with its terminating primary care providers to ensure that this formal notification will be sent to all bonded members.

Under certain conditions, Kaiser Permanente members may be given the option to continue seeing the terminating practitioner if the terminating practitioner agrees to all "Continued Access" criteria and determines that the member qualifies for continued care. Members are informed of this continued access option in a written notification.

F. Hold Harmless Contract Provisions

Kaiser Permanente has the following "hold harmless" provision in our provider contracts, prohibiting contracted providers from balance-billing enrollees in the event of the issuer's insolvency or other inability to continue operations in compliance with Section 10-16-705(3), C.R.S.

Member Hold Harmless. Except as expressly provided in Section 3.4 (Billing Members), Provider (and any Subcontractors) shall look solely to the responsible Payor for compensation for Covered Services rendered to Members, and Provider agrees that in no event (Including non-payment by Payor, insolvency of Payor or breach of this Agreement) shall Provider (or Subcontractor) bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, person acting on the Member's behalf, Official, State or any Medicaid plans, for Covered Services provided under this Agreement. Without limiting the foregoing, Provider shall not seek payment from Members for amounts denied by Payor because (i) billed charges were not customary or reasonable, (ii) the Services were not medically necessary, (iii) the Services were not Authorized, or (iv) Provider failed to submit claims within the appropriate time frame or in accordance with the Provider Manual.

Regulatory Appendix: Hold Harmless. [3 CCR 702-4, Amended Regulation 4-7-1] Provider agrees that the provisions of Section 3.3 of the Agreement, Member Hold Harmless, shall survive the termination of this Agreement for Authorized Services rendered prior to the termination of this Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Members. This provision is not intended to apply to services provided after this Agreement has been terminated. Provider further agrees that this provision supersedes any oral or written contrary agreement now or existing hereafter entered into between the Provider and the Member or persons acting on his/her behalf insofar as such contrary agreement relates to liability for payment of Services provided under the terms and conditions of this Agreement. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Commissioner of Insurance has received written notification of proposed changes.