KAISER PERMANENTE®
Kaiser Permanente Insurance Company

2024
COLORADO ACCESS PLAN
Choice PPO

Contents

I. INTRODUCTION

Carrier Name: Kaiser Permanente Insurance Company ("KPIC")
Network Name: Kaiser Permanente Choice PPO Network
Carrier's Network ID Number: MED001

Type of Network and General Description:
Kaiser Permanente Insurance Company's ("KPIC") Choice PPO Network consists of the CO Permanente Medical Group, Direct Contracts, First Health Complimentary Network ("FH"), and CIGNA PPO Network. Covered persons will access the CO Permanente Medical Group and Direct Contracts within the state of Colorado. Outside of Colorado, covered persons can access the First Health Complimentary Network, in California, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia, and the CIGNA PPO Network in all other states.

Specific Geographic Area(s) covered by the network:
Kaiser Permanente's Choice PPO Network consists of the CO Permanente Medical Group and Direct Contracts and has providers in the State of Colorado and KPIC currently has 2255 enrollees located in the following counties:

Adams County	Eagle County	Lake County	Park County
Alamosa County	El Paso County	Larimer County	Phillips County
Arapahoe County	Elbert County	Las Animas County	Prowers County
Bent County	Fremont County	Logan County	Pueblo County
Boulder County	Garfield County	Mesa County	Routt County
Broomfield County	Gilpin County	Montezuma County	Sedgwick County
Chaffee County	Grand County	Montrose County	Summit County
Delta County	Jefferson County	Morgan County	Teller County
Denver County	Kit Carson County	Otero County	Weld County
Douglas County	La Plata County	Ouray County	

Website identification:
Enrollees can access the directory of providers contracted with the Kaiser Permanente Choice PPO Network by visiting https://choiceproducts-colorado.kaiserpermanente.org/choiceppo-plan/

Contact information:
Enrollees may call Customer Service at 1-855-364-3184 or 711 (TTY) for assistance.

II. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESS

A. Summary of the carrier's network adequacy standards measured and results of measurements

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.

KFHP utilizes Quest Analytics, a geographical analysis tool, to calculate the distance between the enrollee's residence to the nearest provider or facility.

Geographic Access

The following counties do not meet the geographic access requirements established 3 CCR 702-4-2-53 for enrollees (excluding Dentists and Pharmacies) when breaking down network adequacy by county classifications; the results are as follows*:

Large Metro Areas

1. Denver County: Gynecology, OB/GYN; Pulmonology

Metropolitan Areas

1. El Paso County: Addiction (Substance Use Disorder) Counselor; Inpatient and Residential Behavioral Health Facility Services
2. Weld County: Gynecology, OB/GYN; Ophthalmology

Micropolitan Areas

1. Eagle County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Chiropractor; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Occupational Therapy; Oncology - Medical, Surgical; Oncology - Radiation/Radiation Oncology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Physical Therapy; Podiatry; Rheumatology; Skilled Nursing Facilities; Speech Therapy; Vascular Surgery
2. Garfield County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Cardiology; Cardiothoracic Surgery; Chiropractor; Dermatology; ENT/Otolaryngology; Gastroenterology; General Surgery; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Occupational Therapy; Oncology - Medical, Surgical; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Orthotics and Prosthetics; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Physical Medicine & Rehabilitation; Physical Therapy; Plastic Surgery; Podiatry; Primary Care; Psychiatry; Psychology; Pulmonology; Rheumatology; Skilled Nursing Facilities; Social Worker; Speech Therapy; Urology; Vascular Surgery
3. La Plata County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology;

Cardiac Surgery Program; Cardiology; Cardiothoracic Surgery; Chiropractor; Dermatology; Emergency Medicine; Endocrinology; ENT/Otolaryngology; Gastroenterology; General Surgery; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Neurology; Oncology - Medical, Surgical; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Orthotics and Prosthetics; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Physical Medicine & Rehabilitation; Plastic Surgery; Podiatry; Primary Care; Psychiatry; Psychology; Pulmonology; Rheumatology; Skilled Nursing Facilities; Social Worker; Urology; Vascular Surgery

4. Mesa County: Allergy and Immunology; Chiropractor; Dermatology; Inpatient and Residential Behavioral Health Facility Services; Ophthalmology; Opioid Treatment Program; Orthotics and Prosthetics; Outpatient Dialysis; Plastic Surgery; Psychology; Skilled Nursing Facilities; Urology
5. Pueblo County: Addiction (Substance Use Disorder) Counselor

6. Summit County: Addiction (Substance Use Disorder) Counselor; Neurology; Podiatry

Rural Areas

1. Alamosa County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Inpatient and Residential Behavioral Health Facility Services; Neurology; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Outpatient Dialysis; Psychology; Rheumatology; Skilled Nursing Facilities; Urgent Care
2. Chaffee County: Addiction (Substance Use Disorder) Counselor; Inpatient and Residential Behavioral Health Facility Services; Ophthalmology; Opioid Treatment Program; Podiatry; Skilled Nursing Facilities

3. Delta County: Allergy and Immunology; Chiropractor; Dermatology; Gynecology, OB/GYN; Inpatient and Residential Behavioral Health Facility Services; Ophthalmology; Opioid Treatment Program; Orthotics and Prosthetics; Outpatient Dialysis; Pediatric Primary Care; Plastic Surgery; Primary Care; Skilled Nursing Facilities; Urology
4. Fremont County: Addiction (Substance Use Disorder) Counselor
5. Lake County: Addiction (Substance Use Disorder) Counselor; Inpatient and Residential Behavioral Health Facility Services; Opioid Treatment Program; Podiatry; Skilled Nursing Facilities
7. Logan County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Chiropractor; Dermatology; Emergency Medicine; ENT/Otolaryngology; Gastroenterology; Gynecology, OB/GYN; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Neurology; Neurosurgery; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Outpatient Dialysis; Outpatient Infusion/Chemotherapy; Physical Medicine & Rehabilitation; Psychology; Skilled Nursing Facilities; Social Worker; Urgent Care; Urology
8. Montezuma County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Cardiac Surgery Program; Cardiology; Cardiothoracic Surgery; Chiropractor; Dermatology; Emergency Medicine; Endocrinology; ENT/Otolaryngology; Gastroenterology; General Surgery; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Neurology; Oncology - Medical, Surgical; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Orthotics and Prosthetics; Outpatient Clinical

Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Physical Medicine & Rehabilitation; Plastic Surgery; Podiatry; Primary Care; Psychiatry; Pulmonology; Rheumatology; Skilled Nursing Facilities; Social Worker; Urology; Vascular Surgery

9. Montrose County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Chiropractor; Dermatology; Emergency Medicine; Gastroenterology; General Surgery; Gynecology, OB/GYN; Inpatient and Residential Behavioral Health Facility Services; Oncology - Medical, Surgical; Ophthalmology; Opioid Treatment Program; Orthopedic Surgery; Orthotics and Prosthetics; Outpatient Dialysis; Pediatric Primary Care; Plastic Surgery; Podiatry; Primary Care; Psychiatry; Pulmonology; Skilled Nursing Facilities; Social Worker; Urgent Care; Urology
10. Morgan County: Addiction (Substance Use Disorder) Counselor; Dermatology; Emergency Medicine; Gastroenterology; General Surgery; Gynecology, OB/GYN; Neurology; Ophthalmology; Opioid Treatment Program; Orthopedic Surgery; Outpatient Dialysis; Pediatric Primary Care; Podiatry; Primary Care; Psychology; Skilled Nursing Facilities; Social Worker; Urgent Care; Urology
11. Otero County: Addiction (Substance Use Disorder) Counselor; Dermatology; Emergency Medicine; Gastroenterology; Gynecology, OB/GYN; Neurology; Ophthalmology; Opioid Treatment Program; Orthopedic Surgery; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Primary Care; Psychiatry; Psychology; Pulmonology; Social Worker; Surgical Services (Outpatient or ASC); Urgent Care; Urology
12. Routt County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Cardiothoracic Surgery; Chiropractor; Dermatology; Emergency Medicine; Gastroenterology; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Occupational Therapy; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Outpatient Dialysis; Outpatient Infusion/Chemotherapy; Pediatric Primary Care; Physical Medicine & Rehabilitation; Podiatry; Primary Care; Psychiatry; Psychology; Pulmonology; Rheumatology; Skilled Nursing Facilities; Social Worker; Speech Therapy; Surgical Services (Outpatient or ASC); Urology; Vascular Surgery

CEAC (Counties with Extreme Access Considerations)

1. Bent County: Addiction (Substance Use Disorder) Counselor; Dermatology; Emergency Medicine; Gastroenterology; Gynecology, OB/GYN; Neurology; Ophthalmology; Opioid Treatment Program; Orthopedic Surgery; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Primary Care; Psychiatry; Psychology; Pulmonology; Social Worker; Urgent Care; Urology
2. Kit Carson County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Chiropractor; Dermatology; Emergency Medicine; Endocrinology; ENT/Otolaryngology; Gastroenterology; General Surgery; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Neurology; Neurosurgery; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Orthotics and Prosthetics; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Physical Medicine & Rehabilitation; Plastic Surgery; Primary Care; Psychiatry; Psychology; Pulmonology; Rheumatology; Social Worker; Urgent Care; Urology
3. Las Animas County: Addiction (Substance Use Disorder) Counselor; Gynecology, OB/GYN; Opioid Treatment Program; Pediatric Primary Care
4. Ouray County: Allergy and Immunology; Gynecology, OB/GYN; Inpatient and Residential Behavioral Health Facility Services; Ophthalmology; Opioid Treatment Program; Orthotics and

Prosthetics; Outpatient Dialysis; Skilled Nursing Facilities

13. Phillips County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Chiropractor; Dermatology; Emergency Medicine; Endocrinology; ENT/Otolaryngology; Gastroenterology; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Neurology; Neurosurgery; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Outpatient Dialysis; Physical Medicine & Rehabilitation; Plastic Surgery; Psychology; Rheumatology; Skilled Nursing Facilities; Social Worker; Urgent Care; Urology
5. Prowers County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Cardiothoracic Surgery; Chiropractor; Dermatology; Emergency Medicine; Endocrinology; ENT/Otolaryngology; Gastroenterology; Gynecology, OB/GYN; Infectious Diseases; Nephrology; Neurology; Neurosurgery; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Orthopedic Surgery; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Pediatric Primary Care; Physical Medicine & Rehabilitation; Plastic Surgery; Podiatry; Primary Care; Psychiatry; Psychology; Pulmonology; Rheumatology; Social Worker; Urgent Care; Urology; Vascular Surgery
6. Sedgwick County: Addiction (Substance Use Disorder) Counselor; Allergy and Immunology; Chiropractor; Dermatology; Emergency Medicine; Endocrinology; ENT/Otolaryngology; Gastroenterology; Gynecology, OB/GYN; Infectious Diseases; Inpatient and Residential Behavioral Health Facility Services; Nephrology; Neurology; Neurosurgery; Oncology - Radiation/Radiation Oncology; Ophthalmology; Opioid Treatment Program; Optometry for Routine Pediatric Vision; Outpatient Clinical Behavioral Health; Outpatient Dialysis; Physical Medicine & Rehabilitation; Plastic Surgery; Psychology; Rheumatology; Skilled Nursing Facilities; Social Worker; Urgent Care; Urology

Pharmacy Providers

The Choice PPO pharmacy network includes all KP pharmacies as well as MedImpact pharmacies. All counties meet the geographic access requirements established in 3 CCR 702-4-2-53.

Access to Services and Waiting Time Standards

This network adequacy standard cannot be measured considering that the Choice PPO Plans are new plans effective in 2024.

Availability Standards

The following counties did not have enough contracted providers to meet the requirements of the "provider to enrollee" ratio standards set forth in section 7 of 4-2-53:

Primary Care Providers: Garfield, La Plata

OB/GYN: Garfield, La Plata

Pediatricians: Garfield, La Plata

Mental health/Behavioral health providers: Garfield, La Plata

Mental health/Behavioral health facilities: Garfield, La Plata

Substance Use disorder care providers: Garfield, La Plata

Substance Use disorder care facilities: Garfield, La Plata

B. Carrier's quantifiable and measurable process for monitoring and assuring 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 and all hospital services), as stated in DOI regulation.

Our contracts with providers require them to notify us of any adds/changes/deletions to their provider roster as they occur. We also identify the expectations we have for reasonable accessibility, and we have a communication process with our 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 contracted 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. Carrier's description of all applicable standards used for selecting and tiering providers

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 Choice PPO network is supplemented with a high volume of contracted providers.

Provider Tiering

The Colorado network doesn't utilize any provider tiering that would result in variable copayments, coinsurance, or deductibles.

D. Carrier's quality assurance standards

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 Kaiser Foundation Health Plan of Colorado's Vice President, Quality Safety, and Research and by Colorado Permanente Medical Group's Vice President and Chief Quality Officer. Membership includes physicians and health plan 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:

- Behavioral Health Quality Oversight Committee (BHOC)
- Continuum of Care Quality Oversight Committee (CCOC)
- Credentialing/Privileging Committee (CPC)
- Government Programs Quality Oversight Committee (GPOC)
- Integrated Safety Quality Oversight Committee (ISOC)
- Quality Metric Oversight Committee (QMOC)
- Regional Services Quality Oversight Committee (RSOC)

E. Carrier's description of corrective actions process that will be used to remedy networks found to be inadequate.

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

As of the time of this filing, Kaiser Permanente is reporting numerous network adequacy issues, but many of them will be closed as we continue to expand the Choice PPO network. We are currently in the process of contracting with additional providers for the Choice PPO network, especially in the counties and specialties addressed in section II.A above.

F. If a network is found to be inadequate, the carrier will explain/describe specific actions to be taken, including remedies, timeframes, schedule for implementation, and proposed notifications and communications with the Division, providers and policyholders.

KPIC maintains a network adequacy process that applies to all KPIC members covered under a KPIC group health policy. The network adequacy policy assures that when a member is unable to obtain covered services from an In-Network Provider or contracted provider within the Network Adequacy Standards, Availability Standards, or Geographic Access Standards, the covered services will be processed at the In-network benefit.

In the event that no providers are available for a specific specialty in a specific county and the Kaiser Permanente Choice PPO Network is not able to meet the Colorado Network Access and Availability standards, KPIC will make its best efforts to negotiate a Letter of Agreement (LOA) if an enrollee needs to receive covered medical services form an Out-of-Network Provider or if the KPIC enrollee has self-referred to an Out-of-Network Provider to receive covered services not offered by an In-Network Provider. It is at the discretion of the Out-of-Network Provider to accept the contractual terms and agree to the LOA.

To further address any deficiencies in the network, KPIC will begin educating all new members on its network adequacy process which includes options available to them if they experience problems getting an appointment timely and will add verbiage to its member microsite specific to the network adequacy process and options available to members for PY 2024.

G. The carrier's process to assure that a covered person is able to obtain a covered benefit, at the In-Network Provider level of benefit, from an Out-of-Network Provider should the carrier's network prove to not be sufficient.

An enrollee is requested to contact Customer Service at 1-855-364-3184 for assistance in finding an available In-Network Provider. If an enrollee who resides in a county with an inadequate network has already received care from an Out-of-Network , it is recommended that he/she notify KPIC through Customer Service at 1-855364-3184 about the care received and the reason for seeing that Out-of-Network Provider. Customer Service will reach out to KPIC's internal operations department to validate the network inadequacy. Once it has been determined that the enrollee obtained care from an Out-of-Network Provider due to an inadequate network, a notation is placed on KPIC's claim processing system to have the claim paid at the In-Network Provider level. The Explanation of Benefits (EOB) that the enrollee receives will indicate that the claim was paid at the In-Network Provider benefit level. When an enrollee seeks covered services from an Out-of-Network Provider because of the deemed inadequacy of the Choice PPO Network, the claim is processed at the In-Network Provider level of benefits and the enrollee is held harmless by KPIC from any balance billing. In cases of network inadequacy, KPIC will make best efforts to negotiate a Letter of Agreement (LOA) if an enrollee needs to receive covered medical services from an Out-of-Network Provider or if the KPIC enrollee has self-referred to an Out-of-Network Provider to receive covered services not offered by an In-Network Provider. It is at the discretion of the Out-of-Network Provider to accept the contractual terms and agree to the LOA.

H. The carrier's process for monitoring access to in-network physician specialist services for emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory services at its In-Network facilities.

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.

III. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

A. Location(s)/availability of provider directory(ies), how often it is updated, and availability in other languages.

KPIC makes available its provider listing through (1) its Customer Service line (1-855-364-3184); (2) group employer; and (3) electronically via its website:. The Certificate of Insurance (COI), under the HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS section, contains the following provision:

"To verify the current participation status of a provider, please call the toll-free number listed in the Kaiser Permanente Choice PPO Network directory. A current copy of KPIC's Kaiser Permanente Choice PPO Network is available from Your employer or You may call the phone number listed on Your ID card or You may visit KPIC's website at https://choiceproducts-colorado.kaiserpermanente.org/choiceppo-plan/

Upon request, KPIC will provide a translated directory within 5 business days upon receipt of request. The languages available for directory translation are based on the employer group's demographics.

B. Full description of the referral process, including at a minimum:

1. A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services; except that a health benefit plan may offer variable deductibles, coinsurance and/or copayments to encourage the selection of certain providers.

The KPIC PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the In-Network Provider Tier or the Out-of-Network Provider Tier. Deductibles, coinsurance and/or copayments may be higher for services rendered by Out-of-Network Providers.

2. A process for timely referrals for access to specialty care

The Choice PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the In-Network Provider Tier or the Out-of-Network Provider Tier. Physicians may make recommendations as they deem appropriate in their best medical judgement.

3. A process for expediting the referral process when indicated by medical condition.

The Choice PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the In-Network Provider Tier or the Out-of-Network Provider Tier.

4. A provision that referrals approved by the carrier cannot be retrospectively denied except for fraud or abuse.

   The KPIC health benefit plans are open-ended plans where insureds are free to self-refer in the In-Network Provider Tier and the Out-of-Network Provider Tier. KPIC plans that utilize the Choice PPO Network under the In-Network Provider Tier do not utilize a referral process. Physicians may make such referrals as they deem appropriate in their best medical judgment.

   The KPIC PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Choice PPO Network.

5. A provision that referrals approved by the carrier cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.

   The KPIC PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the In-Network Provider Tier or the Out-of-Network Provider Tier.

6. A health benefit plan that offers variable deductibles, coinsurance, and/or copayments shall provide adequate and clear disclosure, as required by law, of variable deductibles and copayments to enrollees, and the amount of any deductible or copayment shall be reflected on the benefit card provided to the enrollees.

   There is a provision in the Certificate of Insurance (COI) particularly the HOW TO ACCESS YOUR SERVICES and OBTAIN APPROVAL OF BENEFITS section which explains this. The SCHEDULE of BENEFITS (Who Pays What) and MEMBER PAYMENT RESPONSIBILITY section of the COI shows lower cost share values under the In-Network Provider Tier as compared to the Out-of-Network Provider Tier.

   The identification cards provided to enrollees reflect the plan deductible and applicable cost share.

C. The carrier's process allowing members to access services outside the network when necessary.

   The KPIC PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the In-Network Provider Tier or the Out-of-Network Provider Tier.

IV. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

A. Method for informing enrollees of the plan's services and features through disclosures and notices to policyholders.

   KPIC annually provides members with a Certificate of Insurance (COI) summarizing the benefits and services available to each enrollee. Coverage varies depending on the particular plan in which the enrollee is enrolled. Enrollees may obtain a printed copy of the COI by calling Customer Service at 1-855-364-3184 or 711 (TTY).

B. Required disclosures, pursuant to Colorado Revised Statutes Section 10-16-704(9).

1. Carrier's grievance procedures, which shall be in conformance with Division regulations concerning prompt investigation of health claims involving utilization review and grievance procedures

Regarding grievances involving utilization review decisions, such as denial of pre-service and concurrent claims due to Pre-Certification determination, KPIC, has outlined its procedures under the APPEALS AND COMPLAINTS section of the Certificate of Insurance (COI). The COI, under the HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS section contains the following provision:

"Please refer to the APPEALS AND COMPLAINTS section on Pre-Service Claims of this Certificate of Insurance for Pre-certification request process. Also, refer to the same section where a benefit is denied, in whole or in part, due to a failure to obtain Pre-certification for services rendered by an Out of-Network Provider."

Additionally, the urgent and non-urgent pre-service and concurrent care claims and appeals procedures are explained in detail under the APPEALS AND COMPLAINTS section of the COI, which also includes: the applicable time frame for filing an appeal; the need for any additional information which KPIC will be requesting from the insureds within a prescribed period; the time frame within which to decide the appeal; the availability of a voluntary second level appeal at the option of the insured; and the availability of the expedited external review if warranted under certain circumstances.

The provisions in the APPEALS AND COMPLAINTS section of the COI are in accord with the Colorado Insurance Code and Division of Insurance (DOI) regulations on prompt investigation of health claims involving utilization review and grievance procedures.

2. The extent to which specialty medical services, including but not limited to physical therapy, occupational therapy, and rehabilitation services are available.

KPIC makes available its provider directory through the KPIC website. https://choiceproducts-colorado.kaiserpermanente.org/choiceppo-plan/. The Certificate of Insurance, under the HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS section contains the following provision:

"To verify the current participation status of a provider, please call Customer Service at 1-855-364-3184. A current copy of KPIC's In-Network Provider directory is available from Your employer or You may call the phone number listed on Your ID card or You may visit KPIC's web site at https://choiceproducts-colorado.kaiserpermanente.org/choiceppo-plan/

3. The carrier's procedures for providing and approving emergency and non-emergency medical care

Emergency Services are covered twenty-four (24) hours a day, even (7) days a week, anywhere in the world. Enrollees are advised via their COI and their Customer Service toll free number that if one has an Emergency Medical Condition, to call 911 or go to the nearest emergency room.

If an insured receives Emergency Care/Services and cannot, at the time of emergency, reasonably reach an In-Network Provider, that emergency care rendered during the course of the emergency will be paid for in accordance with the terms of the Group Policy, at benefit levels at least equal to those applicable to treatment by an In-Network Provider for emergency care.

4. The carrier's process for choosing and changing network providers

The KPIC products are open-ended plans allowing access to providers in and outside the Choice PPO Network. There are no restrictions on choice of providers or changing In-Network Providers.

5. The carrier's documented process to address the needs, including access and accessibility of services, of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical or mental disabilities

KPIC's Language Assistance Tagline (Help with Your Language) together with the Notice of Non-Discrimination are attached to significant documents that are sent to the enrollees pursuant to Section 1557 of the Affordable Care Act (Act). The Language Assistance Tagline offers language assistance services in the form of oral interpretation at no cost to members by calling 1-800-632-9700 or 711 (TTY).

Choice PPO Provider Directory addresses the needs for people with disabilities. The directory has a field that identifies if a provider's office is ADA accessible. Currently, this field is not searchable, however, the directory will be updated to a searchable format with a target of Q1 of 2024.

6. The carrier's documented process to identify the potential needs of special populations

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

- In order to identify the potential needs of special populations, KPCO has developed an Equity, Inclusion, and Diversity program, described below:

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 HR Strategy Design Consultant III, and the HR Strategy Design Consultant II.

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, develop and endorsed by the National Office of Equity, Inclusion and Diversity, focusing on integrating diversity and inclusion into all aspects of the organization. One main area of 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).

7. The carrier's methods for assessing the health care needs of covered persons, tracking and assessing clinical outcomes from network services, assessing needs on an on-going

basis, assessing the needs of diverse populations, and evaluating consumer satisfaction with services provided

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
- Able to emphasize member's individual health history and personal habits
- Inclusive of 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 but not limited to, the Member Experience Tracking Evaluation and Opinion Research Survey (METEOR), Press Ganey Patient Satisfaction Survey, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the review and evaluation of complaints and appeals.

Survey feedback is collected through three methods dependent on the survey. CAHPS and METOER surveys are the most robust using mail, phone and web-based surveys. The Press Ganey Patient Survey is primarily administered via phone and mail.

Both the CAHPS and METEOR Surveys assess the patients' experiences with both health care received, customer service within the health plan and information about plan and benefits. The Press Ganey Patient survey follows a specific visit and focuses on patient satisfaction with their visit including appointment access and scheduling; physician's manner, attitude; overall visit satisfaction; and coordination of care.

V. PLANS FOR COORDINATION AND CONTINUITY OF CARE

A. The carrier's documented process for ensuring the coordination and continuity of care for covered persons referred to specialty providers

The Choice PPO Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the In-Network Provider Tier or the Out-of-Network Provider Tier. Physicians may make recommended referrals as they deem appropriate based on their best medical judgment. Physicians are contractually obligated to render care in a manner that assures availability, adequacy and continuity of care to enrollees.

Additionally, physicians are contractually obligated to render services in accordance with generally accepted medical practice and professionally recognized standards. Thus, physicians are required to ensure the coordination and continuity of care for enrollees referred to specialty care providers.

B. The carrier's documented process for ensuring the coordination and continuity of care for covered persons using ancillary services, including social services and other community resources

Ancillaries are contractually obligated to render care in a manner that assures availability, adequacy and continuity of care to enrollees. Additionally, ancillaries are contractually obligated to render services in accordance with generally accepted medical practice and professionally recognized standards. Thus, ancillaries are required to ensure the coordination and continuity of care for enrollees.

C. The carrier's documented process for ensuring appropriate discharge planning.

CO Permanente Medical Group and Direct Contracts Providers comprising of the Choice PPO Network are contractually obligated to render services in accordance with generally accepted medical practice and professionally recognized standards. Enrollees who seek services from the Choice PPO Network utilize KPIC's Permanente Advantage as appropriate. Permanente Advantage takes accountability for discharge planning, as needed for KPIC enrollees.

D. The carrier's process for enabling enrollees to change primary care providers

Under the In-Network Provider Tier enrollees are not required to enroll with a specific primary care provider. Enrollees are free to change primary care providers at any time and without prior notice to the insurance carrier.

E. The carrier's proposed plan and process for providing continuity of care in the event of contract termination between the carrier and any of its In-Network Providers or in the event of the carrier's insolvency or other inability to continue operations. The proposed plan and process must include an explanation of how enrollees shall be notified in the case of a provider contract termination, the carrier's insolvency, or of any other cessation of operations, as well as how policyholders impacted by such events will be transferred to other providers in a timely manner.

KPIC's process for Continuity of Care involving termination of PCPs, specialists, or facilities is as follows:

I. If a provider terminates or is removed from KPIC's network, KPIC will identify all enrollees who had services with that Provider in the last 12 months.
II. For enrollees identified, KPIC will provide notification on the provider termination.
III. KPIC will also provide options on continuity of care and how to locate another In-Network provider. Enrollees are provided the telephone number to KPIC's Medical Review Program administered by Permanente Advantage.
IV. Once the enrollee can provide the details on their care they would like to continue, Permanente Advantage will review the request and work with the enrollee and provide options to continue their care.
V. Permanente Advantage will take care of any authorization/referral that is needed for the enrollee to continue services with another provider.
VI. Permanente Advantage will follow enrollee's benefit plans and provisions as well as State/Federal laws and regulations as they continue to help the enrollee with their care transition.
VII. Enrollees will continue to have access to the grievance and appeals process.

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, 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.

The provider contracts require providers to continue to render care and comply with the terms of the contract following a termination for those enrollees who are undergoing a course of treatment or are hospitalized on the date of contract termination. The provider shall, at minimum, comply with Colorado Revised Statutes Section (CRS) 10-16-705. The provider's obligations continue (i) until the course of treatment is completed; (ii) for a period of ninety (90) days or through the current period of active treatment for those enrollees undergoing active treatment for a chronic or acute medical condition, whichever time period is shorter; (iii) throughout the second and third trimester of pregnancy and for the immediate six (6)-week postpartum period , if requested by the enrollee; or (iv) until provider makes reasonable and medically appropriate arrangements to transfer the enrollees to the care of another provider, making such transfer to an in-network provider whenever appropriate (except as specified in subsections (ii) and (iii).

KPIC provides both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information within thirty (30) working days of receipt or issuance of a notice from the In-Network Provider. This notice shall be provided to all enrollees who are identified as patients by the provider, are on a carrier's patient list for that provider, or who have been seen by the provider being removed or leaving the network within the previous twelve (12) months.

F. A carrier must file and make available upon request the fact that the carrier has a "hold harmless" provision in its provider contracts, prohibiting contracted providers from balance-billing covered persons in the event of the carrier's insolvency or other inability to continue operations in compliance with CRS 10-16-705(3) Network access plan requirements and demonstrations.

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.