KAISER PERMANENTE®
Kaiser Permanente Insurance Company

2024
COLORADO ACCESS PLAN

Contents

I. INTRODUCTION

Carrier Name: Kaiser Permanente Insurance Company ("KPIC")
Network Name: KPIC Participating Provider Network
Carrier's Network ID Number: CON001

Type of Network and General Description:

Kaiser Permanente Insurance Company's ("KPIC") Participating Provider Network consists of the First Health Complementary Network ("FH") and CIGNA PPO Network. Covered persons will access First Health Network within the states of Colorado, California, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia and the CIGNA PPO Network in all other states.

First Health Group Corp. (FH) develops and manages for KPIC a primary network of health care providers and hospitals utilized for its Preferred Provider Organization ("PPO") and 3-Tier Point-of-Service (POS) health benefit plans. With PPO health benefit plans, enrollees are encouraged to utilize the services offered by FH through the provision of financial incentives, such as a lower cost sharing. The 3-Tier Point of Service (POS) health benefit plans provide coverage under three (3) Tiers –Tier 1 or the Health Maintenance Organization (HMO) Tier, underwritten by the Kaiser Foundation Health Plan of Colorado; and Tier 2 or the Participating Provider Tier and Tier 3 or the Non-Participating Provider Tier, underwritten by Kaiser Permanente Insurance Company (KPIC). Enrollees with the POS Plans are encouraged to utilize the HMO Tier (Tier 1) which will result in lower cost share but can obtain services from Participating Providers under the Participating Provider Tier (Tier 2) or Non-Participating Provider Tier (Tier 3).

Specific Geographic Area(s) covered by the network:

KPIC's Participating Provider Network consists of the FH Network in the State of Colorado. KPIC currently has 2,255 enrollees located in the following Colorado 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	Pitkin County
Boulder County	Fremont County	Logan County	Prowers County
Broomfield County	Garfield County	Mesa County	Pueblo County
Chaffee County	Gilpin County	Montezuma County	Routt County
Clear Creek County	Grand County	Montrose County	Sedgwick County
Delta County	Jefferson County	Morgan County	Summit County
Denver County	Kit Carson County	Otero County	Teller County
Douglas County	La Plata County	Ouray County	Weld County

Website identification:
Enrollees can access the directory of providers contracted with FH by visiting http://kp.org/kpic-colorado.

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

Pursuant to DOI Amended Regulation # 4-2-53, the FH network was measured using KPIC enrollee information to determine KPIC compliance with Colorado network adequacy standards. The FH network is not intended to meet Dental or Pharmacy requirements. Carriers contracting with the FH network will have their own Dental and/or Pharmacy networks or contract with a separate network for these services.

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

The following counties do not meet the geographic access requirements established in DOI Amended Regulation # 4-2-53 for at least 90% of enrollees (excluding Dentists and Pharmacies) when breaking down network adequacy by county classifications the results are the following:

Metro Areas

1. Weld: Gynecology, OB/GYN, Pediatrics- Routine/Primary Care

Micro Areas

1. Eagle: Inpatient and Residential Behavior Facility Services, Licensed Addiction Counselor, Podiatry, Pulmonology, Skilled Nursing Facilities
2. Garfield: Inpatient and Residential Behavior Health Facility Services, Ophthalmology
3. La Plata: Inpatient and Residential Behavioral Health Facility, Licensed Addiction Counselor, Nephrology, Opioid Treatment Program, Pulmonology
4. Mesa: Inpatient and Residential Behavioral Health Facility, Opioid Treatment Program
5. Summit: Pulmonology

Rural Areas

1. Alamosa: Dermatology, ENT/Otolaryngology, Inpatient and Residential Behavioral Health Facility, Opioid Treatment Program, Urology
2. Chaffee: Licensed Addiction Counselor, Opioid Treatment Program, Outpatient Dialysis
3. Delta: Inpatient and Residential Behavioral Health Facility
4. Lake: Inpatient and Residential Behavioral Health Facility, Podiatry, Skilled Nursing Facilities
5. Logan: Licensed Addiction Counselor, Urgent Care Facilities
6. Montezuma: Inpatient and Residential Behavioral Health Facility, Opioid Treatment Program
7. Montrose: Inpatient and Residential Behavioral Health Facility, Licensed Addiction Counselor
8. Otero: Inpatient and Residential Behavioral Health Facility, Mammography, Neurology, Opioid Treatment Program, Podiatry, Psychiatry, Psychology, Pulmonology, Urology
9. Pitkin: Inpatient and Residential Behavioral Health Facility
10. Routt: Gastroenterology, Inpatient and Residential Behavioral Health Facility, Licensed Addiction Counselor, Neurology, Opioid Treatment Program, Outpatient Dialysis, Urology

CEAC Area

1. Kit Carson: Licensed Addiction Counselor, Opioid Treatment Program
2. Ouray: Inpatient and Residential Behavioral Health Facility
3. Phillips: Licensed Addiction Counselor, Neurological Surgery
4. Prowers: Infectious Disease, Inpatient and Residential Behavioral Health Facility, Nephrology, Opioid Treatment Program, Podiatry, Pulmonology, Urology
5. Sedgwick: Licensed Addiction Counselor, Neurosurgery, Urgent Care Facilities

KPIC contracts with MedImpact for pharmacy benefit management and services. KPIC maintains a network of 865 pharmacy locations. All counties met the geographic access requirements established in DOI Amended Regulation #4-2-53 for at least 90% of enrollees.

Access to Services and Waiting Time Standards

All waiting time standards were met, based on Section 6 of DOI Amended Regulation #4-2-53.

Emergency Care – Medical, Behavioral, Mental Health, and Substance Use: Standards were met. Providers responded to outreach conducted in Q1 and Q2 of 2023. Emergency care for medical, behavioral, mental health, and substance abuse care is available 24 hours a day, 7 days a week.

Urgent Care – Medical, Behavioral, Mental Health, and Substance Use: Standards were met. Providers responded to outreach conducted in Q1 and Q2 of 2023. Urgent care for medical, behavioral, mental health, and substance abuse care is available within 24 hours.

Primary Care – Routine, non-urgent symptoms: Standards were met. Providers responded to outreach conducted in Q1 and Q2 of 2023. Primary Care for non-urgent routine symptoms is available within 7 calendar days 90% of the time.

Initial Non-Emergency Behavioral Health, Mental Health, and Substance Use Disorder Care, initial appointments: Standards were met. Providers responded to outreach conducted in Q1 and Q2 of 2023. Behavioral Health, Mental Health, and Substance use disorder care for initial non-emergency care is available within 7 calendar days 90% of the time.

Follow-up Non-Emergency Behavioral Health, Mental Health, and Substance Use Disorder Care appointments: Standards were met. Providers responded to outreach conducted in Q1 and Q2 of 2023. Behavioral Health, Mental Health, and Substance use disorder care for follow-up non-emergency care is available within 7 calendar days 90% of the time.

Prenatal Care: Standards were met. Providers responded to outreach conducted in Q1 and Q2 of 2023. Prenatal Care is available within 7 calendar days 90% of the time.

Primary Care Access to after-hours care: Providers responded to outreach conducted in Q1 and Q2 of 2023. Primary Care access for after-hours care is available 90% of the time.

Preventive visits/well visits: Providers responded to outreach conducted in Q1 and Q2 of 2023. Preventive visit/well visits care is available within 30 calendar days 90% of the time.

Specialty Care – non-urgent: Providers responded to outreach conducted in Q1 and Q2 of 2023. Specialty Care – non-urgent is available within 30 calendar days 90% of the time.

Availability Standards

The following counties did not meet the requirements of the "Provider to enrollee" ratio standards set forth in section 7 of DOI Amended Regulation #4-2-53:

Mental Health & Behavioral Health: Weld, La Plata, Prowers

Substance Use Disorder Care Providers: Weld, La Plata, Prowers

B. Carrier's quantifiable and measurable process for monitoring and assuring the sufficiency of the network

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

The FH network accessibility standards are monitored monthly for compliance. These standards are measured using valid methodology and presented to the National Quality Oversight Committee (NQOC) for review and approval. Methods of monitoring may include one or more of the following mechanisms: Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, other member satisfaction surveys, telephonic provider access surveys, other access surveys, and an analysis of member complaints related to access.

FH's policies demonstrate the actions taken to demonstrate compliance with geo-access standards. Qualitative and quantitative analysis by product/product line is performed using network adequacy data which includes member complaints/grievances and appeals, accessibility, availability, out-of-network requests, and member experience data (CAHPS or member experience survey).

The results of the above analysis will be reviewed in conjunction with the findings of the network availability and accessibility analyses to identify and prioritize opportunities for improvement. On a monthly basis, the effectiveness of interventions will be assessed through a remeasurement of network adequacy. Analysis of findings will include a comparison of results against standards or goals trended over time to determine effectiveness.

For Virtual Care Services which may be in the form of telehealth, voice-only telephone, or HIPAA-compliant email/online or video visits, FH provides the same covered services, whether the providers see the patients in their office or consult with them via Virtual Care Services. This helps to meet the health care needs of enrollees and gives them access to health care services. On occasion, in remote or rural areas, availability standards are not able to be met due to lack of, or absence of, qualified providers and hospital facilities. Even in counties where there may not be a pediatrician or OB/GYN available, there are participating PCPs who can provide services to the enrollees. FH monitors counties for new providers and facilities and reaches out to contract with them.

C. Carrier's factors used to build its provider network, including a description of the network and the criteria used to select and/or tier providers.

To build FH's network, FH selects healthcare providers and facilities in a specific area based on necessity demonstrated through monthly geographical access reports.

Doctors

FH chooses network doctors from multiple specialty types as well as primary care. Doctors must meet certain standards and agree to rates before joining the FH network. The standards used vary depending on the doctor's specialty.

FH's credentialing process includes (but is not limited to) the following:

1. Gathering information about background and qualifications through a formal application process.
    a. Checking the background information
    b. Checking the information against reliable sources, including the National Practitioner Data Bank and the American Board of Medical Specialties
2. Contracting:
    a. Any state where the doctor or behavioral health practitioner reports an active medical license and sees the enrollees
    b. Schools and hospital programs, to be sure training is complete and accepted by the specialty board
    c. The National Technical Information Service, Drug Enforcement Agency, or Controlled Substance Registration, as confirmation that the doctor or behavioral health practitioner is authorized to write prescriptions
    d. Medicare/Medicaid, to be sure the doctor or behavioral health practitioner is not banned from caring for Medicare/Medicaid patients.
3. Reviewing the doctor/behavioral health practitioners:
    a. Personal history, to determine if any disciplinary actions have been taken
    b. Malpractice insurance, to confirm active coverage
    c. Malpractice claims history
    d. Hospital privileges, to determine if privileges have been lost or limited
    e. Work history and employment background
    f. Information with FH's Credentialing and Performance Committee, to determine whether the doctor or behavioral health practitioner should be included as participating in the network

Some of the specific information gathered includes:

Provider name, phone number, and office location: This information is self-reported at least every three years or more often, according to state or federal requirements on the application. It is accepted through a signed document from the doctor or behavioral health practitioner that states the information is accurate and correct.

Provider gender: This information is self-reported at least every three years or more often, according to state or federal requirements on the application. It is accepted through a signed document from the doctor or behavioral health practitioner that states the information is accurate and correct.

Specialty/Specialties: This is the doctor's special field of practice or expertise. For behavioral health practitioners, it may include the practitioner's discipline or provider type. If the provider has contracted with FH to provide services in more than one specialty, all will be listed. This information is self-reported at least every three years or more often, according to state or federal requirements on the application. The practitioner's highest level of training in his/her specialty is checked. Board certification status through primary source verification is checked. This is the process of confirming with the certifying board and/or facility where the doctor or behavioral health practitioner completed residency training.

Languages spoken: This information includes the languages that the practitioner speaks and is self-reported at least every three years or more often, according to state or federal requirements on the application. It is accepted through a signed document from the doctor or behavioral health practitioner that states the information is accurate and correct.

Hospital affiliation: This is a listing of the hospitals where the provider has privileges. If an enrollee requires hospital care, they may be directed to one of the hospitals listed. This information is self-reported on the application. FH's checks the practitioner's hospital affiliations by contacting hospitals to verify the information at least every three years or more often, if state or federal regulations require it.

Medical group affiliation: This is a listing of the group practice that the practitioner is part of (when applicable). This information is self-reported at least every three years or more often, according to state or federal requirements on the application. It is accepted through a signed document from the doctor or behavioral health practitioner that states the information is accurate and correct.

Board certification: When a physician is board certified, it means that he/she has applied for and been awarded certification from the American Board of Medical Specialties, American Osteopathic Association, or other FH-recognized boards, depending on the specialty. To become board certified, a physician must:

- Graduate from an accredited professional school
- Complete a specific type and length of training in a specialty
- Practice for a specified amount of time in that specialty
- Pass an examination given by the professional specialty board

Board certification is a voluntary process. Most certifying boards now require physicians to be recertified at specified intervals. The specialty board certification of the practitioner is self-reported on the application. It is checked before contracting and at least every three years or

more often, according to state or federal requirements, through one of the following primary sources:

- American Medical Association
- American Board of Medical Specialties
- American Osteopathic Association Physician Profile Report
- American Board of Podiatric Surgery
- American Board of Podiatric Orthopedics and Primary Podiatric Medicine
- American Board of Lower Extremity Surgery, if applicable

Office status: This shows whether a provider is accepting new patients. This information is self-reported at least every three years or more often, according to state or federal requirements on the application. It is accepted through a signed document from the doctor or behavioral health practitioner that states the information is accurate and correct. Practitioners may also tell FH of updates between credentialing cycles.

Hospitals

One of the ways FH reduces health care costs is by building networks with a focus on quality and cost. FH evaluates and selects hospitals for the FH network using both quality and cost-efficiency measures. FH measures quality using specific established standards. To measure cost efficiency, FH compares each hospital to other hospitals in the area.

FH's credentialing policy and/or business participation requirements are part of the contract with participating hospitals. These hospitals must have a current license and accreditation from The Joint Commission. If the Joint Commission doesn't accredit the hospital, it must be accredited by one of the following:

- The American Osteopathic Association (AOA)
- Det Norske Veritas Healthcare (DNV)
- An accrediting entity that FH participation requirements, or state/regulatory standards deem appropriate

According to FH's contract, participating hospitals must:

- Inform FH about any material changes of licensure or accreditation status
- Keep enough malpractice and general liability insurance or self-insurance
- Provide evidence of such insurance upon request

Though the criteria may vary according to hospital type, in general, FH requires hospitals to:

- Show evidence of accreditation from a recognized accrediting agency for services and sites where they treat members
- Provide evidence of good standing with state and federal regulatory bodies

- Supply evidence that the provider is Medicare-certified or approved for certification when part of a Medicare market
- Have current professional liability insurance in adequate amounts

Some of the specific information they collect includes:

Hospital name: The hospital self-reports its name on the first questionnaire. They update the questionnaire at least every three years or more often, according to state or federal requirements. It is also part of their continuing contract information.

Accreditations:

Hospitals must:

- Send a letter or certificate of accreditation from an accrediting agency that they recognize for services and sites where they treat members
- Show evidence of good standing with state and federal regulatory bodies
- Show a letter of certification or approval for certification from the Centers for Medicare & Medicaid Services

FH's recognized accrediting agencies include:

- The Joint Commission (TJC)
- The American Osteopathic Association (AOA)
- Det Norske Veritas Healthcare (DNV)

FH checks accreditation when beginning to first credential the hospital, and every three years thereafter.

Location and Phone Number: The hospital reports its location and phone number on the initial questionnaire. They update the questionnaire every three years, and it is part of the hospital contract.

Provider Tiering

The Participating Provider Network does not utilize any provider tiering that would result in variable or cost share differentials such as copayments, coinsurance, or deductibles within the Participating Provider Tier.

D. Carrier's quality assurance standards

First Health's Quality Management (QM) program oversees network quality and standards which includes the care provided to members by participating providers/facilities.

The FH network includes doctors, hospitals, and other healthcare professionals and facilities in the Colorado market. FH has provider standards for access to care and service that comply with Colorado regulations. This is to ensure that the FH network has enough licensed healthcare providers available to meet members' needs. On a monthly basis, FH checks network adequacy based on member needs. These results are used to develop and implement market contract plans.

KPIC also receives a monthly termination report that is reviewed to identify gaps in the network and works with FH on developing a plan to locate and partner with medical professionals to enhance patient access and outcomes. FH continues to engage, promote, and contract with all provider types throughout the State of Colorado. First Health is also open to any willing provider and tries to ensure all members have access to their chosen provider.

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

FH uses network analytics to drive key recruitment targets monthly. Targets are based on areas where members do not have access to a provider or facility within the prescribed distance standard.

KPIC may request FH to conduct additional recruitment based on new enrollees in new geographical locations or other special requests. These additional requests are pursued throughout the calendar year and are prioritized, deployed out to negotiators, and then contracts are negotiated accordingly.

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.

FH shall analyze the network using its geographical access data to identify deficiencies and search for available providers in identified areas for the next annual network adequacy filing. FH will attempt to recruit these providers to remediate coverage gaps prior to the next annual network adequacy filing.

If no providers are available for a specific specialty in a specific county, the FH network will not be able to meet the Colorado Network Access and Availability requirements. In cases of network inadequacy, KPIC will make its best efforts to negotiate a Letter of Agreement (LOA) if an enrollee needs to receive covered medical services from a Non-Participating Provider or if the KPIC enrollee has self-referred to a Non-Participating Provider to receive covered services not

offered by a Participating Provider. It is at the discretion of the Non-Participating Provider to accept the contractual terms and agree to the LOA.

Evaluation of the network is ongoing. On at least a monthly basis First Health runs access adequacy reports utilizing KPIC membership. If the percentage of access falls below 90% this is used as a guide to begin the recruitment process. First Health has dedicated resources for recruiting providers. Any network deficiency identified initiates an aggressive recruitment effort within a short period of time.

KPIC has maintained a network adequacy process and policy that applies to all KPIC members covered under a KPIC group health policy with a Colorado situs and covers services from a non-participating provider because of access deficiencies within the participating provider network. The policy states that when a member is unable to obtain covered services from a participating provider or contracted provider due to Network Adequacy Standards, Availability Standards, or Geographic Access Standards, the covered services will be processed at the member's participating/in-network benefit level. The member will be held harmless from any balance billing from the non-participating/out-of-network provider.

G. The carrier's process to assure that a covered person is able to obtain a covered benefit, at the Participating Provider (in-network) level of benefit, from a Non-Participating Provider should the carrier's network prove to not be sufficient.

KPIC has maintained a network adequacy process and policy that applies to all KPIC members covered under a KPIC group health policy with a Colorado situs and covers services from a non-participating provider because of access deficiencies within the participating provider network. The policy states that when a member is unable to obtain covered services from a participating provider or contracted provider due to Network Adequacy Standards, Availability Standards, or Geographic Access Standards, the covered services will be processed at the member's participating/in-network benefit level. The member will be held harmless from any balance billing from the non-participating/out-of-network provider.

An enrollee is requested to contact Customer Service at 1-855-364-3184 or the KPIC Onboarding Team at 303-306-2720 for assistance in finding an available Participating Provider. If an enrollee who resides in a county with an inadequate network has already received care from a Non-Participating Provider, it is recommended that he/she notify KPIC through Permanente Advantage (Permanente Advantage is KPIC's Third Party Administrator for pre-certification and Utilization Management/Case Management) at 1-888-525-1553 about the care received and the reason for seeing that Non-Participating Provider.

Permanente Advantage 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 a Non-Participating provider due to an inadequate network, a notation is placed on KPIC's claim processing system to have the claim paid at the Participating Provider level. The Explanation of Benefits (EOB) that the enrollee receives will indicate that the claim was paid at the Participating Provider benefit level.

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 participating facilities.

With a dedicated team of contracting resources, FH makes the best effort to contract with hospital-based physicians that are not included as part of the hospital agreement. Hospitals are encouraged to ensure that all hospital-based physicians, including but not limited to anesthesiologists, radiologists, pathologists, and emergency department physicians, agree to accept a Payer's payment as payment in full, subject to applicable copayments, coinsurance, and deductibles and to agree to the hold harmless provisions in the contract.

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: http://kp.org/kpic-colorado. 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 Participating Provider directory. A current copy of KPIC's Participating 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 website at http://kp.org/kpic-colorado."

Upon request, KPIC will provide the translation of the pertinent page/s of the directory within 5 business days of receipt of the 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 and 3-Tier POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating Provider Tier. Deductibles, coinsurance and/or copayments may be higher for services rendered by Non-Participating Providers.

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

The KPIC PPO and 3-Tier POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating Provider Tier. Physicians may make recommendations as they deem appropriate in their best medical judgment.

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

The KPIC PPO and 3-Tier POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating 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 Participating Provider Tier and the Non-Participating Provider Tier. KPIC plans that utilize the Participating Provider Network under the Participating 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 and 3-Tier POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating Provider Tier.

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 and 3-Tier POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating 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 Participating Provider Tier as compared to the Non-Participating 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 and 3-Tier POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating 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 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 a Non-Participating 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: http://kp.org/kpic-colorado. 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 the toll-free number listed in the Participating Provider directory. A current copy of KPIC's Participating Provider is available from the enrollees employer or call the phone number listed on the enrollee's ID card or the enrollee may visit KPIC's website at http://kp.org/kpic-colorado."

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 a Participating Provider, that emergency care rendered during 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 a Participating Providers 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 Participating Provider Network. There are no restrictions on the choice of providers or changing Participating 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).

   KPIC provides Language and Translations Assistance information in the APPEALS AND COMPLAINTS Certificate of Insurance (COI) provided to the member, see below.

   "Language and Translation Assistance
   *You may request language assistance with Your Claim and/or Appeal by calling Member Services at 1- 800-632-9700 or 711 (TTY). SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-632-9700. TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-632-9700. CHINESE (**中文**): **如果需要中文的帮助**, 请拨打这个号码 1-800-632-9700. NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-632-9700."*

   Additionally, the ACA 1557 notice requirements consisting of the Notice of Non-Discrimination and Language Assistance Tagline is attached to KPIC COIs as well as to all member-facing significant documents. The member may request language assistance services in the 18 languages indicated therein by contacting Member Services at phone number 1-800-632-9700. The Member Services call center will appropriately transfer the member to the language assistance line. Language Assistance services are at no cost to the member.

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

FH can support more than 200 languages. They have contracted with Voiance Interpreter Network to provide professional translation language services when a caller needs such services. While they employ several Spanish-speaking Customer Service Representatives, they encourage the use of Voiance Interpreter Network to assist with translation. Additionally, their online provider locator tools are available 24 hours a day, 365 days a year, via their website. All their contracted providers can be found within their tool.

Users that click on "Locate a Provider" can search for network providers by name, zip code, specialty, or condition, in addition to other criteria to narrow the results (i.e., language spoken, hospital affiliation, distance to travel). They can then compare providers, display maps and driving directions to the provider locations, as well as create a list of user-specific search results that can be viewed/downloaded, emailed, or faxed. If a more traditional directory is desired, users can access their Directories Online application through the "Create a Directory" option. Directories Online allows for a directory to be created on an as-needed basis at the city, county, or state level. When ready, the system sends an email notification to the requester with a link to the directory in a PDF format, ready for downloading or printing.

Equity, Inclusion, and Diversity

To identify the potential needs of special populations, KPIC is included in KFHP's 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.

Equity, Inclusion, and Diversity (EID) councils exist at both the national and regional levels. They are responsible for engaging employees in EID initiatives and programs and are accountable for achieving diversity-related goals.

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

FH operates a quality of care, quality of service, and grievance complaint and resolution process that accepts complaints and grievances from enrollees. FH tracks, analyzes, and works with KPIC to resolve the complaints.

KPIC's Onboarding Team and Operational Teams track all member complaints in Member Case Tracker (MCT), KPIC's internal tracking system, and analyze the data to determine trends and identify process improvements.

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 KPIC PPO and 3-Tiered POS Plans do not utilize a referral process. Insureds are free to self-refer to any specialist in the Participating Provider Tier or the Non-Participating Provider Tier. Physicians may make recommended referrals as they deem appropriate based on their best medical judgement. 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.

First Health Providers comprising of the KPIC Participating Provider Network are contractually obligated to render services in accordance with generally accepted medical practice and

professionally recognized standards. Enrollees who seek services from the Participating Provider 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

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 participating 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 the 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 participating 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 the 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 the 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.

The provider contracts require providers to continue to render care and comply with the terms of the contract following 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 Participating 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.

FH contracts with providers in Colorado include a State Law Coordinating Provision Exhibit that contains a hold harmless provision consistent with the requirements of CRS 10-16-705(3), that prohibits a network provider from collecting from an enrollee any money owed to such network provider by a carrier.