KAISER PERMANENTE®
Kaiser Permanente Insurance Company

2021
COLORADO ACCESS PLAN

Contents

I. INTRODUCTION

Carrier Name: Kaiser Permanente Insurance Company ("KPIC")
Network Name: 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 Complimentary Network ("FH") and the Direct Contracted Providers ("DCP") to enhance KPIC's primary network.

Effective January 1, 2021, First Health Group Corp. will replace KPIC's previous network, Private Healthcare Systems, Inc. ("PHCS"). First Health Group Corp. (First Health), a wholly owned subsidiary of Aetna Inc., develops and manages a primary network of health care providers and hospitals that are utilized by insurance carriers in the provision of preferred provider organization ("PPO") and 3-Tiered Point-of-Service health benefit plans. KPIC also directly contracts with providers (referred to as "Direct Contracted Providers") for primary care, specialty care and hospital services. With PPO health benefit plans, enrollees are encouraged to utilize the services offered by the FH Network and DCP through the provision of financial incentives such as a lower cost share. The 3-Tiered 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 (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 to 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 for KPIC and the DCP. The FH Network is a national provider network accessed specifically according to carrier needs and where KPIC has enrollees. FH Network and the DCP has providers in the State of Colorado and KPIC currently has 2,209 enrollees located in the following counties:

Adams	Arapahoe	Archuleta	Boulder	Broomfield	Chaffee
Clear Creak	Delta	Denver	Douglas	Eagle	El Paso
Elbert	Garfield	Gilpin	Grand	Gunnison	Jefferson
La Plata	Lake	Larimer	Logan	Mesa	Moffat
Montezuma	Montrose	Morgan	Ouray	Park	Rio Grande
Routt	San Miguel	Summit	Teller	Washington	Weld

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

Per the corrective action plan submitted in the 2020 Network Adequacy filing regarding KPIC's direct contract providers, KPIC has established a process to ensure compliance with the CO DOI Amended Regulation 4-22-55, Section 6 requirements for provider directory updates and audits, including documentation outlining the

process. This directory is updated monthly and will be found using this link http://info.kaiserpermanente.org/html/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 3 CCR 702-4-2-53, the FH Network and the DCP were measured using KPIC enrollee information to determine KPIC compliance with Colorado network adequacy standards. The FH Network and the DCP are not intended to meet Dental and Pharmacy requirements. Generally speaking, carriers contracting with the FH Network and the DCP will have their own Dental and/or Pharmacy networks or contract with a separate network for these services. The results of the network adequacy findings as they pertain to the FH Network and the DCP will not include the Dental and Pharmacy requirements.

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

When breaking down network adequacy by county classifications the results are the following:

Large Metropolitan Areas

As defined by the Centers for Medicare & Medicaid Services ("CMS") which is based on the US Census Bureau and the Office of Management and Budget criteria, the Participating Provider Network has contracted with more than nine thousand (9,000) providers. All KPIC enrollees have access to providers in the specific specialties and geographic distributions defined in 3 CCR 702-4-2-53 (excluding Dentists and Pharmacies).

Metropolitan Areas

As defined by the Centers for Medicare & Medicaid Services ("CMS") which is based on the US Census Bureau and the Office of Management and Budget criteria, the Participating Provider Network has contracted with more than thirty-five thousand (35,000) providers in Metropolitan Areas. The following counties do not meet the geographic access requirements established in 3 CCR 702-4-2-53 for at least 90% of enrollees (excluding Dentists and Pharmacies):

1. Adams: Gynecology, OB/GYN, Pediatrics – Routine Primary Care, Cardiovascular Disease, General Surgery, Ophthalmology, Orthopedic Surgery
2. El Paso: Cardiac Catheterization Services
3. Larimer: Cardiac Catheterization Services
4. Weld: Gynecology, OB/GYN, Cardiac Catheterization Services

Micropolitan Areas

As defined by the Centers for Medicare & Medicaid Services ("CMS") which is based on the US Census Bureau and the Office of Management and Budget criteria, the Participating Provider Network has

contracted with more than two thousand five hundred (2,500) providers. Although, the majority of specialty types in Micropolitan Areas have at least ninety percent (90%) of enrollees with access to services according to 3 CCR 702-4-2-53, the below specialties did not meet the distance threshold (Excluding dentists and pharmacies):

1. Eagle: Gynecology, OB/GYN, Allergy and Immunology, Endocrinology, ENT/otolaryngology, Gastroenterology, General Surgery, Gynecology Only, Neurology, Orthopedic Surgery, Podiatry, Pulmonology, Rheumatology, Urology, Vascular Surgery, Surgical Services (Outpatient or ASC), Speech Therapy, Inpatient Psychiatric Facility
2. Garfield: Gynecology, OB/GYN, Pediatrics – Routine Primary Care, Allergy and Immunology, Dermatology, Endocrinology, ENT/Otolaryngology, Gastroenterology, General Surgery, Gynecology Only, Nephrology, Neurology, Orthopedic Surgery, Physiatry, Rehabilitative Medicine, Psychology, Pulmonology, Rheumatology, Urology, Vascular Surgery, Cardiac Catheterization Services, Outpatient Dialysis, Surgical Services (Outpatient or ASC), Diagnostic Radiology, Occupational Therapy, Speech Therapy, Inpatient Psychiatric Facility
3. La Plata: Cardiothoracic Surgery, Endocrinology, Infectious Disease, Nephrology, Neurology, Psychiatry, Psychology, Pulmonology, Rheumatology, Vascular Surgery, Cardiac Catheterization Services, Critical Care Services – Intensive Care Units, Surgical Services (Outpatient or ASC), Speech Therapy, Inpatient Psychiatric Facility, Orthotics and Prosthetics
4. Mesa: Endocrinology, Gynecology Only, Plastic Surgery, Cardiac Catheterization Services, Speech Therapy

Rural Areas

As defined by the Centers for Medicare & Medicaid Services ("CMS") which is based on the US Census Bureau and the Office of Management and Budget criteria, the Participating Provider Network has contracted with more than two thousand five hundred (2,500) providers. Although, the majority of specialty types in Rural Areas have at least ninety percent (90%) of enrollees with access to services according to 3 CCR 702-4-2-53, the below specialties did not meet the distance threshold (excluding dentists and pharmacies):

1. Chaffee: Pediatrics – Routine Primary Care, Gastroenterology, Licensed Clinical Social Worker, Oncology – Medical, Surgical, Orthopedic Surgery, Podiatry, Psychiatry, Pulmonology, Acute Inpatient Hospitals, Outpatient Dialysis, Surgical Services (Outpatient or ASC), Skilled Nursing Facilities, Speech Therapy
2. Delta: Pediatrics – Routine Primary Care, Endocrinology, Gynecology Only, Plastic Surgery, Cardiac Catheterization Services, Speech Therapy
3. Lake: Gastroenterology, Gynecology Only, Neurology, Oncology – Medical, Surgical, Orthopedic Surgery, Podiatry, Psychiatry, Pulmonology, Surgical Services (Outpatient or ASC), Skilled Nursing Facilities, Occupational Therapy, Speech Therapy, Inpatient Psychiatric Facility
4. Logan: Pediatrics Routine Primary Care, ENT/Otolaryngology, Psychiatry, Psychology, Acute Inpatient Hospitals, Physical Therapy, Occupational Therapy, Speech Therapy, Inpatient Psychiatric Facility
5. Montezuma: Cardiothoracic Surgery, Endocrinology, Infectious Diseases, Licensed Clinical Social Worker, Nephrology, Neurology, Psychiatry, Psychology, Pulmonology, Rheumatology, Vascular Surgery, Cardiac Catheterization Services, Critical Care Services – Intensive Care Units, Surgical Services (Outpatient or ASC), Speech Therapy, Inpatient Psychiatric Facility, Orthotics and Prosthetics

6. Montrose: Pediatrics – Routine Primary Care, Cardiovascular Disease, Endocrinology, Gastroenterology, Gynecology Only, Oncology – Medical, Surgical, Ophthalmology, Podiatry, Pulmonology, Urology, Acute Inpatient Hospitals, Cardiac Catheterization Services, Physical Therapy, Speech Therapy
7. Morgan: Acute Inpatient Hospitals, Outpatient Dialysis, Inpatient Psychiatric Facility
8. Rio Grande: Gynecology, OB/GYN, Allergy and Immunology, Dermatology, Endocrinology, Gynecology Only, Infectious Diseases, Licensed Clinical Social Worker, Neurology, Oncology – Medical, Surgical, Oncology – Radiation/Radiation Oncology, Plastic Surgery, Psychiatry, Psychology, Pulmonology, Rheumatology, Urology, Cardiac Catheterization Services, Surgical Services (Outpatient or ASC), Occupational Therapy, Speech Therapy, Inpatient Psychiatric Facility

Counties with Extreme Access Considerations ("CEAC") Areas

Most specialty types in CEAC Areas have at least ninety percent of enrollees with access to services according to 3 CCR 702-4-2-53, except for the counties and specialties below (excluding dentists and pharmacies):

1. Archuleta: Cardiothoracic Surgery, Endocrinology, Infectious Diseases, Psychiatry, Pulmonology, Rheumatology, Cardiac Catheterization Services, Critical Care Services – Intensive Care Units, Surgical Services (Outpatient or ASC), Speech Therapy, Inpatient Psychiatric Facility, Orthotics and Prosthetics
2. Gunnison: Gynecology Only, Speech Therapy
3. Moffat: ENT/Otolaryngology, Gastroenterology, Gynecology Only, Neurology, Urology, Cardiac Catherization Services, Outpatient Dialysis, Surgical Services (Outpatient or ASC), Speech Therapy
4. Ouray: Endocrinology, Cardiac Catheterization Services, Speech Therapy
5. San Miguel: Endocrinology, Cardiac Catheterization Services, Speech Therapy

Pharmacy Providers

The FH Network and the DCP do not include pharmacies. KPIC contracts with MedImpact for pharmacy benefit management and services. KPIC maintains a network of 634 pharmacies at 623 locations in the Large Metro and Metro counties within a 30-mile radius and an additional 208 pharmacies at 203 locations in the Micro, Rural, & CEAC Counties within a 60-90-mile radius.

Access to Services and Waiting Time Standards

2021 will be KPIC's first year utilizing FH. There is no data but KPIC will track waiting time complaints from KPIC enrollees. Practitioners are required contractually to comply with all applicable laws, including those pertaining to appointment wait times.

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: Eagle, Elbert, Garfield, Ouray, Park, San Miguel, Washington

Obstetricians, Gynecologists, OBGYN: Adams, Arapahoe, Boulder, Broomfield, Chaffee, Denver, Douglas, Eagle, Garfield, Grand, Jefferson, Lake, Larimer, Mesa, Morgan, Summit, Weld

Pediatricians: Arapahoe, Boulder, Denver, Douglas, Eagle, Garfield, Jefferson, La Plata, Larimer, Mesa, Morgan, San Miguel, Weld

Behavioral Health, Mental Health and Substance Abuse Disorder Providers: Arapahoe, Boulder, Chaffee, Denver, Douglas, Eagle, Garfield, Gilpin, Grand, Gunnison, Jefferson, La Plata, Larimer, Mesa, Moffat, Morgan, Ouray, Park, San Miguel, Weld

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

KPIC 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 annually 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: 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. It states that qualitative and quantitative analysis by product/product line will be 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 an annual 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.

FH remediation efforts consist of annually analyzing geographic distribution of providers, member to practitioner ratios, member complaints, closed practice data, and trending data.

The DCP supplements the FH network. Network inadequacies are remediated with FH as KPIC is not expanding the DCP network at this time.

For Telehealth services, FH provides the same covered services, whether the providers see the patients in their office or consult with them via Telehealth. 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 PCP's who can provide services to our enrollees. FH monitors counties for new providers and facilities and reach out to contract with them.

C. Carrier's description of all applicable standards used for selecting and tiering providers

To build FH's network, they look at how many primary and specialty care doctors are in a specific area. They also look at hospitals and other health care providers. This way they can make enough providers available to meet an enrollee's health care needs.

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 isn't 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 our 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 practitioner's:
    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 (-ies): 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. They check the practitioner's highest level of training in his/her specialty. They also check board certification status through primary source verification. 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:

- Tell us 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's 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 we 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 is part of the hospital contract.

The DCP process for selecting physicians and non-physicians utilizes the following attributes:

- Joint Commission (TJC), Centers Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and third-party payer requirements for delegated credentialing agreements.

The DCP process for selecting medical groups that include ancillary and hospital facilities adhere to the following credentialing standards:

- Joint Commission (TJC), Centers Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and third-party payer requirements for delegated credentialing agreements.

D. Carrier's quality assurance standards

The FH network includes doctors, hospitals and other health care professionals and facilities in the Colorado market. They 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 health care providers available to meet members' needs. This includes urgently needed or emergency services. At least once a year they check network adequacy based on member needs. These results are used to develop and implement market contract plans.

FH has various processes which involve the receipt of information regarding the care provided to members by participating practitioners and providers. This is monitored by their Quality Management (QM) program.

The DCP operates according to the guidelines set forth by The Joint Commission (TJC), Centers Medicare Services (CMS), National Committee for Quality Assurance (NCQA) and third-party payer requirements for delegated credentialing agreements.

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

FH uses data analytics and claim utilization to drive key recruitment targets yearly. Targets are based on highest non par utilization for KPIC which provides FH with their key initiatives and recruitment for the year. These reports are produced the 1st and 4th Quarter every year and serve as their priority recruitment every year.

KPIC may request FH to conduct additional recruitment based on new clients 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.

2021 will be the first year KPIC utilizes FH. There is no information to provide regarding past remediation efforts.

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.

1. General Colorado Access and Availability Corrective Action Plan

FH shall evaluate the geographies to determine if there are available providers in identified geographies with membership for the next renewal cycle (June 2021) and FH shall determine a plan to recruit available providers based on geography and membership by next renewal cycle (June 2021)

In the event that 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 best efforts to negotiate a Letter of Agreement (LOA) if an enrollee needs to receive covered medical services from a non-contracted provider or if the KPIC enrollee has self-referred to a non-contracted provider to receive covered services not offered by a contracted provider. It is at the discretion of the non-contracted provider to accept the contractual terms and agree to the LOA.

2. Essential Community Provider (ECP) Colorado Corrective Action Plan

The FH Network has contracted with over 30% (280) of available ECP providers in CO that are included on the Non-Exhaustive listing published by CMS. No action is required.

Currently the Direct Contracted Providers do not have the functionality to track, report, or provide ECP data.

G. The carrier's process to assure that a covered person is able to obtain a covered benefit, at the in-network level of benefit, from a non-participating provider should the carrier's network prove to not be sufficient.

An enrollee may contact Customer Service at 1-855-364-3184 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 precertification 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 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) which the enrollee receives will indicate that the claim was paid at the Participating Provider benefit level. There is a provision in KPIC's Network Adequacy Policies and Procedures which stipulates that when an enrollee seeks covered services from a Non-Participating Provider as a result of the deemed inadequacy of the Participating Provider network, the affected enrollee is reimbursed at the Participating Provider level of benefits and 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 a non-contracted

provider or if the KPIC enrollee has self-referred to a non-contracted provider to receive covered services not offered by a contracted provider. It is at the discretion of the non-contracted 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 participating facilities.

The FH Network criteria schedules, provider manuals and internal policies require providers to comply with applicable state and/or federal laws as such laws pertain to appointment wait times or access to care. Carriers utilizing the FH Network may forward access complaints to FH to investigate.

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 web site: http://info.kaiserpermanente.org/html/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 web site at http://info.kaiserpermanente.org/html/kpic-colorado."

KPIC has an updated directory for the KPIC DCP. This directory will be updated monthly and will be found using this link http://info.kaiserpermanente.org/html/kpic-colorado for the following network rosters:

1. Boulder Valley IPA
2. Sisters of Charity, Leavenworth
3. Boulder Community Hospital

Upon request, KPIC will provide a translated directory within 3-5 business days upon request. Translated directories will be mailed by KPIC with 48 hours after receipt of the translated directory. 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-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. 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-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 recommendations as they deem appropriate in their best medical judgement.

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

   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.

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

   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.

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-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.

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 which explains this. The Schedule of Benefits (Who Pay 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-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.

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 CRS §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://info.kaiserpermanente.org/html/kpic-colorado (provider directory for the DCP can be accessed

here). 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 enrollee's ID card or the enrollee may visit KPIC's web site at http://info.kaiserpermanente.org/html/kpic-colorado."

Per the corrective action plan submitted in the 2020 Network Adequacy filing, KPIC has established a process to ensure compliance with the CO DOI Amended Regulation 4-22-55, Section 6 requirements for provider directory updates and audits, including documentation outlining the process for KPIC's direct contracted network. This directory will be updated monthly and is found using this link http://info.kaiserpermanente.org/html/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 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 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 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).

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 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 the 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.

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.

   Enrollee issues regarding DCP are escalated to Member Services department. Each operational area is charged with continually improving processes to improve delivery of services and to address issues.

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 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.

First Health and Direct Contracted Providers comprising of the 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

Under the Participating Provider Tier enrollees are not required to enroll with a specific primary care provider. Enrollee 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 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 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.

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 C.R.S. §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 shall make a good faith effort to provide both written notice of a provider's removal, leaving, or non-renewal from the network, and the provider information pursuant to legal and regulatory requirements, within fifteen (15) 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 C.R.S. §10-16-705(3), that prohibits a network provider from collecting from a enrollee any money owed to such network provider by a carrier.

KPIC's contracts with DCP include an additional Member Hold Harmless provisions that state the Provider shall look solely to KPIC for compensation for covered services rendered to enrollees and that Provider agrees that in no event (including non- payment) shall bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any person acting on the enrollee's behalf, official, state or any plans for covered services provided under their agreement. Without limiting the foregoing, provider shall not seek payment from enrollees for amounts denied by KPIC because: (i) services were not medically necessary (ii) services were not approved, (iii) provider failed to submit claims within the appropriate timeframe or in accordance with program requirements.