Appendix A: Colorado Access Plan (HMO) including the Colorado Option Standardized Plans

Colorado Network Access Plan

Health Plan of Colorado

Network ID: CON001

HIOS Issuer ID: 74320

Plan Created On/ Effective Date: June 2023
Plan Renewal Date; June 2024
Revision Dates (Most Recent First): June 16, 2023
Plan Signature Date: June 16, 2023

1. INTRODUCTION

A. PURPOSE

The purpose of this Network Access Plan is to describe Humana Health Plan of Colorado's policies and procedures for maintaining and ensuring that each managed care network offered in Colorado is sufficient and consistent with state and federal requirements. The Colorado Network Access Plan is designed to demonstrate Humana Health Plan of Colorado has:

- An adequate network that is actively maintaining, as well as describe/explain network adequacy results and corrective action processes;
- Procedures to address referrals within the network and to providers outside of the network;
- The required disclosures and notices to inform consumers of the plan's services and features; and
- A documented process and plan for coordination and continuity of care.

B. SCOPE

The information contained in this Colorado Network Access Plan is specific to the following:

<table>
<tr><td>CARRIER</td><td>Humana Health Plan of Colorado</td></tr>
<tr><td>NETWORK</td><td>Colorado HMO</td></tr>
<tr><td>NETWORK ID</td><td>CON001</td></tr>
<tr><td>NETWORK TYPE/ GENERAL DESCRIPTION</td><td>Employer Group Commercial HMO Off Exchange and Colorado Option Standardized Plans</td></tr>
<tr><td>GEOGRAPHIC AREA COVERED BY THE NETWORK</td><td>
<table>
<tr><th colspan="2">Colorado HMO Counties</th></tr>
<tr><td>Adams</td><td>El Paso</td></tr>
<tr><td>Arapahoe</td><td>Jefferson</td></tr>
<tr><td>Boulder</td><td>Larimer</td></tr>
<tr><td>Broomfield</td><td>Teller</td></tr>
<tr><td>Denver</td><td>Weld</td></tr>
<tr><td>Douglas</td><td></td></tr>
</table>
</td></tr>
<tr><td>WEBSITE</td><td>https://www.humana.com/finder/medical?pageId=ed1b7b38065148488dafabe948d97b9f</td></tr>
<tr><td>CONTACT INFORMATION</td><td>Customer Service: 1-800-448-6262</td></tr>
</table>

2. NETWORK ADEQUACY AND CORRECTIVE ACTION PROCESSES A.

Network Adequacy Summary:

Humana's Participating Provider Network is measured against health plan enrollees utilizing the Network Adequacy Availability and Geographic Access Standards defined in Colorado DORA Regulation 4-2-53.

This Colorado HMO network is not narrower than the network used for non-standardized plan in the same metal tier and rating area as required by the Colorado Option Standardized plans.

The Colorado HMO satisfies the Network Adequacy Availability and Geographic Standards as defined in Colorado DORA Regulation 4-2-53 for all provider types and counties where current enrollees are present.

The adequacy standards are met due to a combination of on going contract efforts for available providers and declining membership on this network. In addition, Humana has no members that have selected the Colorado Option Standardized Plan in 2023 that would utilize this network.

B. Provider Network Availability and Access Policy Summary

To establish mechanisms to ensure that provider networks have sufficient numbers and types of practitioners who provide primary care, specialty care and behavioral healthcare. It also provides a standard process to ensure that provider networks have sufficient numbers and types of facilities and ancillary providers.

Humana maintains an adequate network of primary care, specialty care and behavioral healthcare practitioners, as well as facilities and ancillary providers, and monitors how effectively the network meets the needs and preferences of its membership. Humana assess the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of providers in its network when necessary.

To evaluate the availability of providers who provide healthcare services in Colorado for Commercial/SHOP Off-Exchange and Option Standardized health plans, Humana will:

1. Utilize the Availability Standards defined in Colorado DORA Regulation 4-2-53 as the measurable standard for the number of each type of provider/facility.
2. Utilize the Geographic Access Standards defined in Colorado DORA Regulation 4-2-53 as the measurable standards for geographic distribution for each provider type.
3. Analyze performance against the standards for the number of each type of provider/facility at least quarterly*.
4. Analyze performance against the standards for the geographic distribution of each provider type at least quarterly*.

*Humana does not currently utilize telehealth providers to meet healthcare needs and network adequacy standards.

C. Assessment of Network Adequacy

Objective: To monitor access to healthcare services and take action to improve it. This plan is used to facilitate member access to medical and behavioral health providers and health services. The plan activities are designed to:

- Facilitate a sufficient number of primary care, perinatal care, community health workers, specialty, and high-impact providers in the delivery system and align geographic distribution with the member population
- Facilitate timeliness of appointments and medical care both during and after office hours
- Meet the cultural, ethnic, racial and linguistic needs of the member population
- Measure performance against Humana's standards for provider access and availability
- Identify opportunities for improvement

Compliance with provider network adequacy is measured by:

- The ratio of primary care and high-volume specialty practitioners to members.
- The geographic distribution of primary care physicians, high-volume and high-impact specialty practitioners
- The rate of member complaints regarding lack of providers in certain locations, specialties or serving specific cultural, ethnic, racial or linguistic needs
- Analysis of relevant CAHPS questions including practitioner level audit.
- Internal analysis tools used to identify additional providers to contract based on specialty and geography, including emphasis on Essential Community Providers, Perinatal specialists, community health workers and promotoras.

Humana maintains a sufficient network of primary care, mental health, substance use disorder providers and programs, as well as facilities and ancillary providers.

If there is an insufficient number or type of participating adult or pediatric providers or facilities to provide a particular covered health care service, Humana will use best efforts to ensure that members obtain the covered service from a provider or facility within reasonable proximity to the member at in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements when:

1. Humana has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to the covered person or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

2. Humana has an insufficient number or type of participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay

In these circumstances, Humana shall:

1. Inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a non-participating provider when the covered person is diagnosed with a condition or disease that requires specialized health care services or medical services and Humana does not have a participating provider of the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease; or cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

2. Treat the health care services the covered person receives from a non-participating provider as if the services were provided by a participating provider, including counting the covered person's costsharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

3. Ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

4. Have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider and shall provide this information to the regulators upon request.

5. All out of network member access will be to a provider who is appropriately qualified, licensed, and/or enrolled as applicable.

Humana collects and analyzes data from complaints and appeals about network adequacy for the following as outlined in Humana Policy NNO 702-044-09:

1. Non-behavioral healthcare services
2. Behavioral healthcare services
3. Uses the aspects of analysis from 1 & 2 to determine if there are issues specific to particular geographic areas or types of practitioners or providers.

Humana:

1. Prioritizes opportunities for improvement of non-behavioral healthcare services identified from analyses of availability, accessibility, CAHPS survey results and member complaints and appeals
2. Implements interventions on at least one non-behavioral healthcare services opportunity, if applicable
3. Measures the effectiveness of interventions for non-behavioral healthcare services, if applicable
4. Prioritizes opportunities for improvement of behavioral healthcare services identified from analyses of availability, accessibility, CAHPS (Consumer Assessment of Healthcare Providers and Systems) survey results and member complaints and appeals
5. Implements interventions on at least one behavioral healthcare services opportunity, if applicable
6. Measures the effectiveness of interventions for behavioral healthcare services, if applicable

Culturally Responsive Network

To ensure a diverse, culturally response network and gain knowledge of the ethnic composition of our membership, the following is used to support and assess the linguistic and cultural needs of that population, and to make any necessary adjustments to the provider network to meet those needs.

- Humana’s online provider directory identifies languages spoken by each provider and is searchable by languages spoken to aid members in identifying providers who meet their language needs. Translation and interpretation services for any language are available free of charge through Customer Service. Humana also has a Spanish customer service unit and a Spanish version of the website, including the online provider directory, to further assist Spanish-speaking members.

- Humana's efforts to address the needs of covered persons, including, but not limited to children and adults, include offering services in a variety of languages via a translation service for those with limited English proficiency or illiteracy. Humana addresses diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or complex medical conditions of our members by ensuring a diverse panel of associates consider culture and diversity when describing our products and services. Humana offers in person contracting and membership sign-up in a variety of locations considering literacy level and access.

- Humana’s Customer Service department can also assist members in locating providers who meet their cultural, linguistic, physical or mental needs.

- The plan annually reviews member complaints received by the Nurse Advise Line (formerly Clinical Access Team) regarding cultural, ethnic, racial and linguistic needs.

- The plan provides and sends annual notice of requirement for Cultural Competency training for all providers providing services and office staff.

- Providers are sent a demographic survey, used to improve racial health equity, reduce health disparities for covered persons who experience higher rates of health disparities and inequities, and to provide aggregate information about the diversity of the providers in Humana's network. This voluntarily reported demographic data email survey is compiled and reported in the aggregate only. Personally identifiable information is kept confidential and will not be disclosed without the written consent of the reporting provider or office staff member.

D. Participating Provider Selection

The business needs and regulatory requirements (including state specific laws, rules and regulations) of each market network and membership needs, as determined on a market-by market basis, dictate the numbers and types of physicians and other providers with whom the market contracts, so long as such needs do not discriminate in terms of participation, reimbursement, or indemnification against any health care professional who is acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification. Leaders at each local market determine specific network configurations (for example, if a network is "open" or "closed" for a provider specialty type).

All provider contracts contain a hold harmless provision. In addition, provider selection for participation in the Colorado HMO may include but is not limited to the following standards:

Accessibility:

- Must meet Geographic Access Standards defined in Colorado DORA Regulation 4-2-53 for provider type and service area
- Humana makes a priority of contracting with doctors who have admitting privileges at our participating network hospitals. This means the doctor has a relationship with the hospital and is allowed to admit patients there. This helps members go to a hospital that is in their network when hospitalization is needed. If you use a hospital that is not in your specific health insurance plan's network, Humana may pay less or may not pay for the services you receive.

Contractual Compliance: Provider's willingness to accept:

- Humana standard contract language
- Humana offered reimbursement rates. In order to participate in Humana's network, health care providers must be willing to agree to a negotiated rate. These negotiated rates are one advantage of having health insurance because you usually pay less for the services you receive when you visit a health care provider in your Humana network. Humana looks for health care providers who are willing to agree to reimbursement arrangements that reward them for meeting certain performance standards or outcome metrics for their patients.

Quality Compliance:

- Satisfies all applicable credentialing and re-credentialing standards. The credentialing process is a way to verify the qualifications of doctors and other health care providers. The process includes checking education and training, licensure, board certification, malpractice claims history, and other background information that applies to the provider's specialty. Doctors are reevaluated at least every three years.
- Humana also considers member complaints received about specific doctors, hospitals, and other health care providers when deciding whether to continue a provider's contract with our network.

*Provider tiering selection process is not applicable for this network.

E. Corrective Action Process

For networks found to be inadequate, Humana will make best efforts to comply with the deadlines and expectations of Colorado DORA to address corrective action plan upon notification.

Process may include but is not limited to the following:

- Validate networks found to be inadequate
- Identify impacts to policy holders
- Identify available providers for potential contracting opportunities
- Communicate action plan to the Division
- Communicate results of action plan to the Division

F. Corrective Action Plan for Current Network Deficiencies

No corrective action plan required. The adequacy standards were met for the Commercial HMO product and no members have selected the Colorado Option Standardized Plan in 2023 that would utilize this network.

G. Network Inadequacy Waiver Summary

Covered members may obtain Network Inadequacy Waivers to receive a covered benefit, at the in-network level of benefit, from a non-participating provider should Humana's provider network prove to be insufficient in meeting the Geographic Access Standards defined in Colorado DORA Regulation 4-2-53 for the servicing provider type.

The Network Inadequacy Waiver is outlined in the Humana Health Guidance Organization Policy HUM HGO 10-004.

If members are unable to find a participating provider that is reasonably accessible, they should contact the customer service phone number on the back of their member id card for assistance with finding the closest in-network provider or to request a Network Inadequacy Waiver.

3. NETWORK ACCESS PLAN PROCEDURES FOR REFERRALS

A. Directories

Members can search for participating providers using the Find a Doctor tool located at the following web address:

https://www.humana.com/
In addition, .pdf versions of the provider directories can be located at the above link.

Humana refreshes the web-based directory every 24 hours.

Humana's online provider directory identifies languages spoken by each provider and is searchable by languages spoken to aid members in identifying providers who meet their needs. Translation and interpretation services for any language are available free of charge through Customer Service. Humana also has a Spanish customer service unit and a Spanish version of the website, including the online provider directory, to further assist Spanish speaking members.

B. Referrals

The referrals can be made to all providers in the network that are qualified to provide covered specialty services.

Colorado HMO members require PCP referrals to participating specialists. For these members the PCP would assess the clinical need for the member to see a participating specialist, and would communicate such referral recommendation in writing to the participating specialty office. For facility service referrals, the PCP would obtain an authorization number from Humana's Clinical Intake Team (CIT)/Preauthorization Department. Referrals approved by the plan cannot be retrospectively denied except for fraud or abuse and that referrals approved by the plan cannot be changed after the preauthorization is provided unless there is evidence of fraud or abuse.

To ensure referral requests are received and processed in a timely manner the primary care physician ("PCP") must initiate the request via Telephone: 1-800-523-0023 or electronically via Humana.com/Availity.com. (Contact the Provider Deployment Team for information on electronic submissions or call Humana Customer Service (1-800-4HUMANA) for the name of the Humana connectivity consultant for a specific area).

Expedited referrals, denials and/or changes of referrals are all initiated and managed via Telephone: 1-800-523-0023 or electronically via Humana.com/Availity.com.

C. Services Outside the Network

If the PCP needs to refer the HMO member to a non-participating provider or facility, the PCP office would contact CIT/Preauthorization to request prior authorization. CIT would confirm a participating specialist/facility is not available in the HMO provider network, as well as assess clinical indications and medical necessity to issue a ruling for the non-participating provider or facility request. If CIT authorizes the non-par provider or facility referral, an authorization number is issued and written notification is sent to the member and the referred to provider/facility. If CIT denies the non-par services then CIT will work with the member and referring provider to redirect the member to a par provider/facility.

4. NETWORK ACCESS PLAN DISCLOSURES AND NOTICES

Humana members have access to important plan disclosures and notices via the online member portal found at https://www.humana.com/insurance-through-employer-support/guidelines/. Excerpts from the "Guidelines for Humana members" are below, and shall demonstrate Humana's publication of important plan services and features:

A. Exceptions, Grievances, and Appeals

If you're unhappy with some aspect of your coverage or need to make a special request, we want to help. Use these procedures to tell us what's going on. You can also find detailed information in your plan benefit documents about grievances, appeals, and coverage determinations (including exceptions). A coverage determination is advance approval from Humana to cover a drug.

1. <u>Exceptions</u>

Do you want your pharmacy plan to cover a prescription in a special way because of your unique circumstances? Ask for a standard decision or coverage determination (the exact term is used in your plan's contract or Certificate). You, your doctor, or your appointed

representative should call Humana Clinical Pharmacy Review (HCPR) at 1-800-555-CLIN (2546), TTY: 711, Monday through Friday, 8 a.m. to 6 p.m. in your local time zone.

If you prefer, you can deliver a written request to:
Humana Clinical Pharmacy Review (HCPR)
ATTN: Coverage Determinations
P.O. Box 33008
Louisville, KY 40232-3008

2. Grievances

A grievance is a complaint about any aspect of your plan — for example, you have problems with the service you receive, or you believe our notices and other written materials are difficult to understand.

You can file a grievance if your plan fails to provide required notices, give you a decision within the required timeframe, or forward your case to an independent reviewer if you don't receive a decision within the required timeframe. See your plan materials for more details about the timeframe for decisions.

Grievances must be filed within 60 days of when the problem occurred. Please send written grievances to:

Humana Grievances and Appeals
P.O. Box 14165
Lexington, KY 40512-4165
Fax: 1-800-949-2961

Or file a verbal grievance by calling the Customer Service phone number on your Humana member ID card.

When calling or writing about a grievance, please have documents that support your request handy (include them with a written grievance) and tell us:

- Your name
- Your address
- Your telephone number
- Your Humana ID number
- The reason for the grievance

We'll investigate your grievance and inform you of our decision.

3. Appeals

If you disagree with our decision to deny payment for an item or service, you can file an appeal. This is a request for us to reconsider our initial decision. Please note that appeals should be written, however, we will accept oral appeals as required by law. See your plan materials for more details about the timeframe for appeals.

You can appeal our decision if you think:

- We're stopping or reducing coverage for an item or service
- We won't authorize coverage for an item or service we should cover
- We haven't paid (or fully paid) a bill we should pay
- We denied an exception request and you disagree
- We aren't making a decision within the required timeframe

See your plan materials for details about the time frame for appeals. Generally, you can submit your appeal in writing within 60 days of the date of the denial notice you receive. Send it to the address on the Humana Appeals Form. Please include your name, address, Humana ID number, and the reason for the appeal. Also enclose documents that may support your request.

Once we receive your appeal, we'll investigate it and inform you of our decision. For questions about the appeals process, please call the Customer Service phone number on your Humana member ID card.

Please note that appeals should be written. However, we will accept oral appeals as required by law.

B. Emergency and Non-emergency Care

If you or a family member experiences a life-threatening illness or injury, always call 911 or go to the nearest emergency room (ER). Whether you're at home or on the road, your plan pays in-network benefits to providers. There is no need for referrals or authorizations.

1. <u>Emergencies</u>

The list below includes, but is not limited to, situations that require ER treatment.

- Major head trauma
- Chest pain
- Severe abdominal pain
- Falls from greater than 7 feet
- Loss of consciousness
- Infants less than 6 months of age or with a temperature greater than 103 degrees
- Pregnancy bleeding or complications
- Life-threatening allergic reactions
- Severe burns
- Severe choking (cannot breathe or talk)
- Signs or symptoms of stroke or heart attack
- Amputation of a body part
- Near drowning
- Electrical shock
- Severe break or bone fracture

2. <u>Non-emergencies</u>

The list below includes, but is not limited to, non-life-threatening conditions that can be treated by your primary care physician or an urgent care or retail care center in your network.

- Colds and cold-like symptoms, including cough, sore throat, fever
- Flu
- Ear infections
- Minor burns and injuries
- Cuts
- Sprains
- Allergies
- Asthma

C. Finding a Provider in your Network

1. What is a network?

A network is a group of providers in a certain service area that have a contract to work with Humana. These providers agree to give you healthcare services at lower costs. When you visit in-network providers, you usually pay less for services, and the provider submits your claims to Humana for you. When you go to a provider who is not in your network, you pay more for your care. You also may have to file your own claims. Some plans do not provide any coverage for care received from out-of–network providers, except in life-threatening emergencies. Check your coverage details or call Member Service for specific details about your plan.

2. Choose a Primary Care Physician (PCP) from Humana's in-network doctors

Besides a primary care doctor, many of us see a specialist from time to time. Here's a good way to keep track of all your medical care. Choose a family doctor or primary care physician (PCP) to coordinate your care. That way you can be sure all of your tests, medicines, and any specialty care go through one trusted person. This could save you from getting the same test twice or using two medicines together that could hurt your health. Choosing and working with a family doctor could save you time and money, and may also help you prevent health problems.

Remember, with some plans, you must choose a primary care physician to oversee your medical care and provide referrals when you need to see a specialist. Check your policy to see if your specific plan requires this.

3. Changing your Primary Care Physician (PCP)

1. Do you know which PCP you would like to select?

If Yes:

- *you already know the PCP you would like and know he or she is accepting new patients, you can change your PCP online at Humana.com or by calling us. Proceed to step #2 below.*

If No:

- *To find a list of in-network providers, click here (if you know your Humana member ID).*
- *Or, register and login to MyHumana here: Humana.com/logon. Then, click "Find a doctor".*

2. Steps for changing your PCP either online or by phone:

Online:

Note: To change your PCP online you will need either your Humana member ID number or your Social Security Number (if you provided it when you chose your plan). If you do not have either of these, proceed to phone option below.

- *Start by registering for MyHumana*
- *Click "Sign in or Register"* ○ *If registered already, sign in with your user ID and password* ○ If not registered select "Register now as a new user," and then

  "Member" and then click "All other members"

- Once you have logged in to your MyHumana account select Coverage & Benefits from the Coverage, Claims & Spending tab at the top of the screen

The Coverage & Benefits page will open in the same browser window. If the "Change Primary Care Physician" link does not display in the Plan basics section, you may not be eligible to change your PCP online. If you are not eligible to change online, please call 1-800-223-3659 to change your PCP.

- If it displays, click "Change Primary Care Physician" within the Plan Basics section.

- The Change primary care physician tool opens in a new browser window. Enter your information as shown below to search for a doctor
  - Your zip code should be pre-populated in the Zip code field. If it is not pre-populated, enter your zip code
  - Select "Specialty" as the search function
  - Type "Primary" and select the option "All Primary Care Physician Specialties" ○ Click "search"

- After you find your preferred primary care physician:
  - Click "Select" to choose the preferred primary care physician
    - If your primary care physician is not accepting new patients you will be asked if you would like to confirm your selection. If you are an established patient click "ok."
    - If you are not an established patient click "cancel" and select a new primary care physician. ○ Select "Yes" when asked if you are sure you want to change your PCP

- The Change primary care physician tool window should close, and your new primary care physician will be displayed in the Plan basics rendering, along with the date when the change will take effect.

Phone:

- *Call 1-800-223-3659 to change your PCP*
- *Monday through Thursday: 8AM-8PM Eastern Time. Friday: 8AM – 7PM Eastern time.*

Please Note:

Timing: Your PCP change may not be immediately reflected on MyHumana. It may take 24-48 hours to update this information on MyHumana. Please note the effective date upon the change of your PCP within MyHumana. If an image of your Humana member ID card is available on MyHumana, it may also take 7 to 10 days to update the PCP's name on that image. You may visit your new PCP immediately but please note that if you need to see your PCP before you get an updated ID card you may need to contact us by phone

ID Card: *Each time you update your PCP, you will receive a new Humana member ID card in the mail with your new PCP's name on it. Some doctors may not allow you to make an appointment or see them if their name does not appear on your Humana member ID card. If you need to see your new PCP prior to receiving your new Humana member ID card, please contact us at the number above. Remember you*

can always print out your Humana member ID card from MyHumana once is it available.

4. Find a doctor

Humana has different networks of providers for different health plans, so it is important to be sure you select providers from the specific network for your plan. Search for providers using the “Find a doctor or pharmacy” tool on the main page of Humana.com. You can enter your Member ID number from your Humana ID card at the beginning of your search, and you will see only the providers that are in your health plan’s network.

Or, you can log in to your personal account on Humana.com and use the “Find a doctor” tool there. When you are logged-in, the search tool automatically selects the correct provider network for your plan. Read more about saving money by using in-network providers.

You can find a provider by:

Location – You can choose someone near your home or in a specific county or zip code.
Provider type – Get the provider or specialty you need, including doctors, hospitals, clinics, pharmacies, and more.
Name – You can look up a specific provider by name.
Language – You can look for a doctor who speaks the language you or a family member needs.

You'll get your search results by last name. And you'll get details like address, phone number, and office hours. You'll also get driving directions to a provider's office. A Colorado specific disclosure indicating that for there may be times for unique services that a member may be required to cross county or state lines to get in network benefits.

D. Access and Accessibility of Services for Diverse Populations

1. Humana Accessibility Resources:

Humana Insurance Company, Humana Health Plan, Inc. and all of their insurer and health plan affiliates and subsidiaries (collectively, “Humana”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Humana does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Multi-language interpreter services:

If you (or someone you’re helping) have questions regarding your coverage, you have the right to get help and information in your language at no cost. To talk to an interpreter, call Humana Customer Support at the number on the back of your member ID card (TTY services are available).

Language assistance & alternative formats:

Healthcare providers are required by their Humana contracts and federal regulations to comply with all applicable laws, which includes ensuring their Humana-covered patients have “equality of opportunity for meaningful access to healthcare services and activities.” Healthcare providers must also have policies in place to protect patients from

discrimination. The information below may assist providers in meeting these requirements.

Federal laws (ADA and Section 1557) require that healthcare providers have the following in place:

1. Over-the-phone interpretation in at least 150 languages. There are many vendors that offer this service to healthcare providers on a pay-as-you-go basis.
2. Sign language capabilities, either in-person or via video remote interpretation.
3. A notice of nondiscrimination per Section 1557; this must be posted and presented to patients. The notice should state that the practice or facility does not discriminate and provides limited English proficiency (LEP) services and auxiliary aids and services.

Oral interpretation and sign language requirements

Oral interpretation services (including American Sign Language) must be available in the member's language at no cost to the member. Please note:

- More than 300 languages are spoken in the United States.
- A notification of the availability of oral interpretation services should be posted or distributed to patients.
- If patients with limited English proficiency request an interpreter in their language, oral interpretation may be delivered over the phone, in person or via video remote interpretation.
- If a deaf or hard-of-hearing patient requests sign language interpretation, this should be delivered in person or via video remote interpretation.

Doctors, hospitals, and other healthcare providers must provide free language assistance or in-person sign language interpretation at a member's request. If members require communication assistance, they are advised to let the staff know. If the provider will not provide the services they need, they are advised to call Humana Customer Support at the number on the back of your member ID card (TTY services are available) or send an email message to accessibility@humana.com.

Mental Health:

Please call the Member Service number on your Humana ID card before you look for a mental health provider on this Website. Some health plans use a different network of providers for mental health. Our Member Service Specialists will help you find the right providers for your plan. If it is a life-threatening situation, call 911 or go to the nearest emergency room.

Special Health Programs:

Humana has special services to help you if you have complicated medical conditions or certain chronic conditions. Our case management service offers support to members with complicated medical conditions, or those who have been hospitalized. A Humana nurse helps you navigate the healthcare system and assists in coordinating care. Other services help people manage health conditions like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), and other illnesses. These services are voluntary. If you are contacted about one of these special services, we encourage you to participate as most members find these programs to be very helpful. You may choose to discontinue at any time by just letting your care manager know. If you would like more information about these special health services you may call the Health Planning and Support team at 1-800-491-4164.

2. Health Care needs of Covered Persons

Complaints, Grievances and Appeals

At least annually, the Plan reviews member complaints, grievances and appeals to identify and trend access issues. The goal for complaints, grievances and appeals is to be <= 3 per 1000 members.

Overall Findings:
The goal of <=3 grievances per 1000 members was met in both 2021 and 2022. No patterns or trends were identified. No additional action regarding grievances is needed at this time.

	HMO
2023	
# of Complaints	2
Complaints per 1000 members	1
2022	
# of Complaints	2
Complaints per 1000 members	2

Source: April 2022 through April 2023 Clinical Access Team Reports

Findings: No complaint trends identified. Complaints were resolved by the Clinical Intake Team on an individual basis.

Barriers: No barriers noted as all access complaints were resolved by the Clinical Access Team. No assistance or intervention was required by the Market office Network Operations Department.

Recommendations/Actions: None

Request for Out-of-Network Services

	Number of Requests	Out-of-Network Utilized
Total Requests for Out-of-Network Services	*33*	*17*
Medical: • HMO	*33*	*17*
Behavioral Health: • HMO	*0*	*0*

Source – Clinical Metrics Report, April 2022 – March 2023

Humana has determined the following standard as the base for detailed analysis of out of network service requests pertaining to Network Adequacy:

- Network Operations will analyze its provider network when “approved” out-of-network service requests meet or exceed ten requests per 1,000 members.

Upon review, requests are deemed denied or approved. Denials are those requests where a participating provider is available in the members' network and out-of-network services are not warranted. Approvals are requests where a network gap may exist, the member was out-of-area or circumstances warrant approval to minimize member disruption. The number of denials and approvals for this market are 3 Denied and 17 Approved.

The approved out-of-network requests identified, though not comprehensive, include the reasons below. Network Adequacy is the main focus of analysis in order to identify potential gaps, barriers and opportunities for improvement.

- Emergent Services -- Member is seen in an Emergency Room or Urgent Care, or is admitted through the Emergency Room.
- Market Exception -- Approval of an exception is made by market leadership for providers/facilities based on specific business case justifications.
- Referral by PAR Physician -- Regional Medical Director gives approval because member was referred to a nonparticipating provider by a participating provider or by their Primary Care Physician.
- Network Adequacy - Indicates no participating providers/facilities are within the specified mileage/reasonable distance. Network Operations has determined that 4 of the approved service requests are due to no available provider in the network.

The actual utilization of out-of-network services requested indicates:

- 1 member went out-of-network due to geographic distance, and
- No members went out-of-network to see the type of provider they preferred.

Barriers:

- Member lack of understanding of implications when choosing, or being referred to, nonparticipating physicians or facilities.
- Market Exceptions are reviewed and approved on a case by case basis and don't allow for identification of trending/patterns.
- Network Operations contracts with most providers in the rural area already. Members are out-of-area when needing care.

Improvements/Interventions/Actions:

- Continued education of members via various departments (i.e. Customer Service, Clinical Access Team) about their participating/out-of-network benefits and requirements.
- Reminders to providers about availability of educational webinars addressing referrals, authorizations and real-time benefit estimation for their patients. These webinars are promoted via Humana.com and the quarterly newsletter Humana's YourPractice.
- No actions necessary at this time for market exceptions.
- Clinical Intake Department to continue identifying on a monthly basis network gaps and sharing this information with Network Operations for identification of contract opportunities.
- Network Operations will continue to identify contracting opportunities for the rural areas
  Humana Behavioral Health contracting will continue to recruit quality providers.

Conclusions/Recommendations:

Humana will continue to monitor provider turnover and attempt to close any network adequacy gaps that open due to provider movement or provider group mergers / acquisitions. Identifying contract opportunities to strengthen our commercial provider networks remains a priority in the

upcoming year. We will also promote our suite of benefits such as our 24-hour nurse line and to improve member satisfaction with getting the care they need in a manner that meets their schedule.

5. PLANS FOR COORDINATION AND CONTINUITY OF CARE

Humana makes a good faith effort to provide written notice of termination of a discontinued provider at least 30 days prior to the effective date of the change or otherwise as soon as practicable to all members who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a non-renewal.

When a provider is terminated without cause, Humana allows a member in active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates (or in accordance with applicable State or Federal law or regulations). Continued access is also allowed through a six-week postpartum period for a member in their second or third trimester of pregnancy. Active course of treatment is defined as:

1. An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;
2. An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;
3. The second of third trimester of pregnancy, through the postpartum period; or
4. An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

For the purposes of the active course of treatment definition, an ongoing course of treatment includes treatments for mental health and substance use disorders that fall within the definition of active course of treatment. If the member has successfully transitioned to a participating provider, if the member has met or exceeded benefit limitations of the plan, or if care is not medically necessary, continuity of care would no longer apply to the member.

Any decision made for a request for continuity of care is subject to Humana's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

Approved by: Kathleen Smits
Title: Network Lead
Date: June 16, 2023