BEFORE THE MARYLAND INSURANCE ADMINISTRATION

MARYLAND INSURANCE ADMINISTRATION **200 ST. PAUL PLACE, SUITE 2700** **BALTIMORE, MARYLAND 21202** **vs.** **KAISER PERMANENTE INSURANCE CO** **ONE KAISER PLAZA** **OAKLAND CA 94612** **NAIC# 60053**	* * * * * * * * * * * *	**CASE NO:** MIA-2023-03-017

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CONSENT ORDER

This Consent Order is entered into by the Maryland Insurance Commissioner and KAISER PERMANENTE INSURANCE COMPANY ("KPIC" or "Respondent") pursuant to §§ 2-108, 2-204, and 4-113 of the Insurance Article, Maryland Code Annotated, to resolve the matter before the Maryland Insurance Administration ("Administration").

I. RELEVANT REGULATORY FRAMEWORK

1. Each insurer that uses provider panels for health benefit plans offered in the State must assure that its provider panels meet certain adequacy standards. On July 1 of each year each insurer is required to file a report with the Administration demonstrating the insurer's compliance with those standards.

2. Section 15-112 of the Insurance Article provides, in pertinent part:

(a) (1) In this section the following words have the meanings indicated.

* * *

(5) (i) "Carrier" means:

* * *

1. an insurer;

(b) (1) Subject to paragraph (3) of this subsection, a carrier that uses a provider panel shall:

(i) if the carrier is an insurer, nonprofit health service plan, health maintenance organization, or dental plan organization, maintain standards in accordance with regulations adopted by the Commissioner for availability of health care providers to meet the health care needs of enrollees;

* * *

(c) (1) This subsection applies to a carrier that:

(i) is an insurer, a nonprofit health service plan, or a health maintenance organization; and

(ii) uses a provider panel for a health benefit plan offered by the carrier.

(2) (i) On or before July 1, 2018, and annually thereafter, a carrier shall file with the Commissioner for review by the Commissioner an access plan that meets the requirements of subsection (b) of this section and any regulations adopted by the Commissioner under subsections (b) and (d) of this section.

3. The regulations referenced in § 15-112(c)(2)(i) of the Insurance Article are set forth in COMAR 31.10.44.

4. The network adequacy standards are set forth in COMAR 31.10.44.04 -.06 and consist of travel distance standards (COMAR 31.10.44.04), appointment waiting time standards (COMAR 31.10.44.05), and provider-to-enrollee ratio standards (COMAR 31.10.44.06) (collectively, the "Standards").

5. The access plan content and filing requirements are set forth in COMAR 31.10.44.03, which provides, in pertinent part:

.03 Filing of Access Plan.

C. Each annual access plan filed with the Commissioner shall include:

(1) An executive summary in the form set forth in Regulation .09 of this chapter;

(2) The information and process required by Insurance Article, §15-112(c)(4), Annotated Code of Maryland, and the methods used by the carrier to comply with the monitoring requirement under §15-112(c)(5);

(3) Documentation justifying to the Commissioner how the access plan meets each network sufficiency standard set forth in Regulations .04—.06 of this chapter; and

(4) A list of all changes made to the access plan filed the previous year.

6. COMAR 31.10.44.07 allows a carrier to apply for a temporary waiver from compliance with one or more of the Standards provided that certain criteria are met.

7. The criteria that must be met in order to qualify for a waiver of a Standard are set forth in COMAR 31.10.44.07, which states, in pertinent part:

.07 Waiver Request Standards

A. A carrier may apply for a network adequacy waiver, for up to 1 year, of a network adequacy requirement listed in this chapter.

B. The Commissioner may find good cause to grant the network adequacy waiver request if the carrier demonstrates that the physicians, other providers, or health care facilities necessary for an adequate network:

(1) Are not available to contract with the carrier;

(2) Are not available in sufficient numbers;

(3) Have refused to contract with the carrier; or

(4) Are unable to reach agreement with the carrier.

C. A carrier seeking a network adequacy waiver shall submit a written request to the Commissioner that includes the following information:

* * *

(2) A list of physicians, other providers, or health care facilities within the relevant service area that the carrier attempted to contract with, identified by name and specialty, if any, or health care facility type;

(3) A description of how and when the carrier last contacted the physicians, other providers, or health care facilities;

(4) A description of any reason each physician, other provider, or health care facility gave for refusing to contract with the carrier;

(5) Steps the carrier will take to attempt to improve its network to avoid future network adequacy waiver requests.

II. FINDINGS

8. KPIC holds a Certificate of Authority to act as an insurer in the State and uses provider panels for health benefit plans offered in the State. As such, it is subject to § 15-112 of the Insurance Article and the network adequacy standards set forth in COMAR 31.10.44.04 - .06. In addition, KPIC is required to file a network adequacy plan in accordance with COMAR 31.10.44.03.

9. On July 1, 2021, KPIC submitted a Network Adequacy Plan (the "KPIC 2021 Access Plan") to the Administration, supplemented with additional information and documentation on March 11, 2022, April 29, 2022, and June 16, 2022.

10. On July 1, 2021, supplemented with additional information and documentation on March 11, 2022, April 29, 2022, and June 16, 2022, KPIC requested a temporary waiver from compliance with the travel distance standards ("the Travel Distance Waiver Request") for the following provider types: Allergy and Immunology, Chiropractic, ENT / Otolaryngology, Gynecology OB/GYN, Neurology, Pediatrics-Routine/Primary Care, Psychiatry, and Urology; and for the following facility types:

Acute Inpatient Hospitals, Critical Care Services / Intensive Care Units, Inpatient Psychiatric Facility, Skilled Nursing Facilities, and Other Behavioral Health/Substance Abuse Facilities.

11. On July 1, 2021, supplemented with additional information and documentation on April 29, 2022 and June 16, 2022, KPIC requested a temporary waiver from compliance with the appointment waiting time standards (the "Waiting Time Waiver Request") for urgent care (including medical, behavioral health, and substance use disorder services), routine primary care, preventive visit / well visit, non-urgent specialty care, and for non-urgent behavioral health/substance use disorder services.

12. On June 24, 2022, KPIC voluntarily disclosed to the Administration its discovery of the inadvertent inclusion of members of another benefit plan that does not utilize the KPIC provider panel. Such inadvertent inclusion affected the network adequacy filings for 2019, 2020, and 2021, and KPIC requested that the MIA pause any final action on the KPIC 2021 Access Plan to allow time for the correct data to be identified and submitted. The Administration agreed and KPIC submitted corrected data for filing years 2019, 2020, 2021, and 2022 on September 23, 2022, supplemented with additional information and documentation on October 21, 2022 and November 2, 2022.

A. <u>The Access Plan-Travel Distance Standards</u>

13. The data submitted by KPIC in connection with the KPIC 2021 Access Plan failed to demonstrate compliance with the Travel Distance Standards.

14. COMAR 31.10.44.04 provides, in pertinent part:

.04 Travel Distance Standards

A. Sufficiency Standards.

(1) Except as stated in §B of this regulation, each provider panel of a carrier shall have within the geographic area served by the carrier's network or networks, sufficient primary care physicians, specialty providers, behavioral health and substance use disorder providers, hospitals, and health care facilities to meet the maximum travel distance standards listed in the chart in §A(5) of this regulation for each type of geographic area. The distances listed in §A(5) of this regulation shall be measured from the enrollee's place of residence.

(2) When an enrollee elects to utilize a gynecologist, pediatrician, or certified registered nurse practitioner for primary care, a carrier may consider that utilization as a part of its meeting the primary care provider standards listed in §A(5) of this regulation.

* * *

(5) Chart of Travel Distance Standards.

	Urban Area Maximum Distance (miles)	Suburban Area Maximum Distance (miles)	Rural Area Maximum Distance (miles)
Provider Type:			
Allergy and Immunology	15	30	75
***			
Chiropractic	15	30	75
***			
ENT / Otolaryngology	15	30	75
***			
Gynecology OB/GYN	5	10	30
***			

Licensed Clinical Social Worker	10	25	60
***			
Neurology	10	30	60
***			
Pediatrics – Routine / Primary Care	5	10	30
***			
Psychiatry	10	25	60
***			
Urology	10	30	60

* * *

Facility Type:			
Acute Inpatient Hospitals	10	30	60
Critical Care Services / Intensive Care Units	10	30	100
***			
Inpatient Psychiatric Facility	15	45	75
***			
Skilled Nursing Facilities	10	30	60
***			
Other Behavioral Health/Substance Abuse Facilities	10	25	60

15. The final corrected data self-reported by KPIC for 2021 disclosed the following deficiencies based on distance of a provider to an enrollee's address:

(a) Allergy and immunology providers met the required standard for 99.7% of suburban enrollees, leaving 3 members outside the travel distance standard of thirty miles in one zip code, 21842.

(b) Chiropractic providers met the required standard for 99.7% of suburban enrollees, leaving 3 members outside the travel distance standard of thirty miles in one zip code, 21842.

(c) ENT / otolaryngology providers met the required standard for 99.7% of suburban enrollees, leaving 3 members outside the travel distance standard of thirty miles in one zip code, 21842.

(d) Gynecology, OB/GYN providers met the required standard for 99.2% of urban enrollees, leaving 9 members outside the travel distance standard of five miles in two zip codes.

Urban zip codes:
(i) Zip code 21403 has 7 members outside the standard.
(ii) Zip code 20746 has 2 members outside the standard.

(e) Licensed clinical social workers met the required standard for 99.7% of suburban enrollees, leaving 3 members outside the travel distance standard of twenty-five miles in one zip code, 21842.

(f) Neurology providers met the required standard for 98.8% of urban enrollees, leaving 14 members outside the travel distance standard of ten miles in two zip codes.

Urban zip codes:

(i) Zip code 21040 has 1 member outside the standard.
(ii) Zip code 20745 has 13 members outside the standard.

(g) Pediatrics-routine/primary care providers met the required standard for 98.9% of urban enrollees, leaving 13 members outside the travel distance standard of five miles in two zip codes.

Urban zip codes:
(i) Zip code 21403 has 11 members outside the standard.
(ii) Zip code 20746 has 2 members outside the standard.

(h) Psychiatry providers met the required standard for 99.4% of urban enrollees, leaving 7 members outside the travel distance standard of ten miles in one zip code, 21114. The required standard was met for 99.7% of suburban enrollees, leaving 3 members outside the travel distance standard of twenty-five miles in one zip code, 21842.

(i) Urology providers met the required standard for 99.6% of rural enrollees, leaving 3 members outside the travel distance standard of sixty miles in one zip code, 21502.

(j) Acute inpatient hospitals met the required standard for 99.6% of urban enrollees, leaving 5 members outside the travel distance standard of ten miles in two zip codes.

Urban zip codes:
(i) Zip code 21114 has 4 members outside the standard.
(ii) Zip code 21040 has 1 member outside the standard.

(k) Critical care services/ intensive care units met the required standard for 99.6% of urban enrollees, leaving 5 members outside the travel distance standard of ten miles in two zip codes.

Urban zip codes:

(i) Zip code 21114 has 4 members outside the standard.

(ii) Zip code 21040 has 1 member outside the standard.

(l) Inpatient psychiatric facility providers met the required standard for 91% of urban enrollees, leaving 104 members outside the travel distance standard of fifteen miles in ten zip codes.

Urban zip codes:

(i) Zip code 21114 has 8 members outside the standard.

(ii) Zip code 21403 has 33 members outside the standard.

(iii) Zip code 21040 has 8 members outside the standard.

(iv) Zip code 20706 has 2 members outside the standard.

(v) Zip code 20743 has 18 members outside the standard.

(vi) Zip code 20745 has 16 members outside the standard.

(vii) Zip code 20746 has 5 members outside the standard.

(viii) Zip code 20747 has 4 members outside the standard.

(ix) Zip code 20748 has 5 members outside the standard.

(x) Zip code 20785 has 5 members outside the standard.

(m) Skilled nursing facilities met the required standard for 99% of urban enrollees, leaving 11 members outside the travel distance standard of ten miles in three zip codes. The required standard was met for 99.7% of suburban enrollees, leaving 3 members outside the travel distance standard of thirty miles in one zip code, 21842.

Urban zip codes:

(i) Zip code 20879 has 2 members outside the standard.
(ii) Zip code 20886 has 8 members outside the standard.
(iii) Zip code 21040 has 1 member outside the standard.

(n) Other behavioral health/substance abuse facilities met the required standard for 83% of urban enrollees, leaving 196 members outside the travel distance standard of fifteen miles in twenty zip codes. The required standard was met for 97.1% of suburban enrollees, leaving 32 members outside the travel distance standard of forty miles in four zip codes. The required standard was met for 99.6% of rural enrollees, leaving 3 members outside the travel distance standard of ninety miles in one zip code, 21502.

Urban zip codes:

(i) Zip code 20706 has 11 members outside the standard.
(ii) Zip code 20710 has 1 member outside the standard.
(iii) Zip code 20737 has 11 members outside the standard.
(iv) Zip code 20740 has 8 members outside the standard.
(v) Zip code 20743 has 20 members outside the standard.
(vi) Zip code 20745 has 16 members outside the standard.
(vii) Zip code 20746 has 8 members outside the standard.
(viii) Zip code 20747 has 9 members outside the standard.
(ix) Zip code 20748 has 11 members outside the standard.
(x) Zip code 20781 has 2 members outside the standard.
(xi) Zip code 20783 has 2 members outside the standard.
(xii) Zip code 20784 has 14 members outside the standard.
(xiii) Zip code 20785 has 9 members outside the standard.
(xiv) Zip code 20904 has 10 members outside the standard.

(xv) Zip code 21040 has 6 members outside the standard.
(xvi) Zip code 21061 has 11 members outside the standard.
(xvii) Zip code 21114 has 8 members outside the standard.
(xviii) Zip code 21222 has 5 members outside the standard.
(xix) Zip code 21224 has 1 member outside the standard.
(xx) Zip code 21403 has 33 members outside the standard.

Suburban zip codes:
(i) Zip code 21037 has 4 members outside the standard.
(ii) Zip code 21401 has 12 members outside the standard.
(iii) Zip code 21409 has 13 members outside the standard.
(iv) Zip code 21842 has 3 members outside the standard.

B. The Travel Distance Waiver Request and Additional Mitigating Factors

16. The July 1, 2021 Travel Distance Waiver Request and the additional supplemental information submitted on March 11, 2022 and June 16, 2022 included data and information to address the deficiencies reported in the original KPIC 2021 Access Plan submitted on July 1, 2021, but did not address the additional deficiencies included in the final corrected data submitted on September 23, 2022. Additionally, the final corrected data submitted on September 23, 2022 eliminated those deficiencies reported in the original KPIC 2021 Access Plan that were not applicable to the access plan. The Travel Distance Waiver Request included data and information demonstrating that for certain deficiencies there were no available providers and health care facilities to contract with KPIC within the required distance standard, and for other deficiencies KPIC has been unable to reach an agreement with available providers or the providers have refused to contract with KPIC. KPIC included a description of its comprehensive process for continued monitoring of deficient areas for available

providers to recruit. KPIC also included a description of its unsuccessful efforts to locate any additional providers and health care facilities within the required distance standards in specific zip codes using both internal reporting, such as enrollee referrals, claims data, and demographics, and external resources, such as CMS data. Finally, KPIC included a description of ongoing negotiations and continued good faith efforts to contract with providers identified as recruitment targets in other zip codes to resolve the deficiencies for enrollees outside the travel distance standard.

17. The Administration has found good cause to grant KPIC's Travel Distance Waiver Request for the travel distance standards for the following provider types: Gynecology OB/GYN, Neurology in zip code 20745, Pediatrics-Routine/Primary Care, Psychiatry in zip code 21114, and Urology; and for the following facility types: Acute Inpatient Hospitals in zip code 21114, Critical Care Services/Intensive Care Units in zip code 21114, Inpatient Psychiatric Facilities, Skilled Nursing facilities in zip codes 20879 and 20886, and Other Behavioral Health/Substance Abuse Facilities in all zip codes with the exception of zip code 21842. The waivers for the travel distance standards are granted for one year.

18. KPIC did not submit additional waiver requests for the remaining deficiencies included in the final corrected self-reported data submitted on September 23, 2022.[1] Additionally, waiver requests for deficiencies reported as no longer applicable using the corrected data were not granted.

[1] At the conclusion of the Administration's review of the 2021 filing, it found that the following deficiencies exist in zip code 21842: Allergy and immunology, Chiropractic, ENT / Otolaryngology, Licensed Clinical Social Workers, Psychiatry, Skilled Nursing Facilities, and Other Behavioral Health / Substance Use Facilities. KPIC did not request a waiver for these deficiencies.

19. KPIC provided documentation to the Administration that it has voluntarily instituted a remediation plan for the non-compliant travel distance standards that will apply to all claims for services received in 2021. In implementing this plan, KPIC will assume that members who received care from an out-of-network provider would have opted for an in-network provider if KPIC's network had met the travel distance standard. To make such members whole, the member's out-of-pocket costs for the out-of-network care will not be allowed to exceed the cost for the same service if it had been received on an in-network basis. This process will determine the member's appropriate in-network liability and any amounts that exceed that liability will be paid at 100% of billed charges for covered services. The resulting calculation is then reconciled against any previous payment for that claim and a member refund is issued.

C. The Access Plan-Appointment Waiting Time Standard

20. The data submitted by KPIC in connection with the KPIC 2021 Access Plan failed to demonstrate compliance with Appointment Waiting Time Standards.

21. COMAR 31.10.44.05 states, in pertinent part:

> .05 Appointment Waiting Time Standards
>
> A. Sufficiency Standards.
>
> (1) Subject to the exceptions in §B of this regulation, each carrier's provider panel shall meet the waiting time standards listed in §C of this regulation for at least 95 percent of the enrollees covered under health benefit plans that use that provider panel.

(2) When it is clinically appropriate and an enrollee elects to utilize a telehealth appointment, a carrier may consider that utilization as a part of its meeting the standards listed in §C of this regulation.

* * *

C. Chart of Waiting Time Standards

Waiting Time Standards	
Urgent care (including medical, behavioral health, and substance use disorder services)	72 hours
Routine Primary Care	15 Calendar Days
Preventive Visit/Well Visit	30 Calendar Days
Non-Urgent Specialty Care	30 Calendar Days
Non-urgent behavioral health/substance use disorder services	10 Calendar Days

22. The data self-reported by KPIC disclosed the following deficiencies:

(a) Urgent care (including urgent behavioral health/substance use disorder services) met the 72-hour standard for 74.38% of enrollees, representing a deficiency of 20.62 percentage points.

(b) Routine primary care met the required standard of 15 calendar days for 80.89% of enrollees, representing a deficiency of 14.11 percentage points.

(c) Preventive visit / well visit met the required standard of 30 calendar days for 89.26% of enrollees, representing a deficiency of 5.74 percentage points.

(d) Non-urgent specialty care met the required standard of 30 calendar days for 89.47 of enrollees, representing a deficiency of 5.53 percentage points.

(e) Non-urgent behavioral health/substance use disorder services met the required standard of 10 calendar days for 80.48% of enrollees, representing a deficiency of 14.2 percentage points.

D. The Waiting Time Waiver Request and Additional Mitigating Factors

23. The Waiting Time Waiver Request, including the supplemental information submitted on April 29, 2022 and June 16, 2022, failed to demonstrate that the providers necessary for an adequate network were not available to contract with KPIC, were not available in sufficient numbers, refused to contract with KPIC, or were unable to reach an agreement with KPIC. KPIC failed to provide sufficient evidence to demonstrate that KPIC engaged in adequate provider recruitment efforts to address the extent of the deficiencies in the waiting time standards.
24. KPIC has failed to satisfy the criteria for a waiver set forth in COMAR 31.10.44.07, and its Waiting Time Waiver Request must be denied.
25. The Waiting Time Waiver Request described KPIC's efforts to proactively assist enrollees in finding appointments within the applicable appointment waiting time standard, and to expand its current network adequacy policy to include a remediation plan for appointment waiting time in addition to travel distance. The remediation plan states that when a member is unable to obtain covered services from an in-network provider due to deficiencies regarding the appointment waiting time standards, covered services received from an out-of-network provider will be processed at the member's in-network benefit level. The member will be held harmless from any balance billing from the out-of-network provider.

To identify members eligible for the remediation plan, KPIC reviewed its member complaint tracking log for all issues reported in 2021, but did not identify any member complaints related to wait time issues. KPIC also provided to the Administration detailed descriptions and timelines for its plans to train staff and educate members regarding the enhanced network adequacy policy, including options available if a member experiences difficulties in getting an appointment timely.

26. COMAR 31.10.44.02B(27) requires reporting appointment waiting time from the initial request to the earliest date offered. KPIC reported the time elapsed between the member requesting the appointment and having the appointment. KPIC stated that its appointment waiting time surveys are conducted by a vendor that collects information from providers based on the time elapsed between the member requesting the appointment and having the appointment. Waiting times calculated using this methodology exaggerate the actual wait time.

27. KPIC reported that the Coronavirus pandemic impacted the ability to collect waiting time data and that its contracted Outbound Contact Centers were often informed that providers were unable to provide information due to COVID-19 restraints.

III. CONCLUSIONS OF LAW

28. The Administration concludes that KPIC violated § 15-112 of the Insurance Article and COMAR 31.10.44.03C by submitting an access plan that failed to comply with the required travel distance standards and appointment waiting time standards.

29. Section 4-113 of the Insurance Article states in pertinent part:

(b) The Commissioner may deny a certificate of authority to an applicant or, subject to the hearing provisions of Title 2 of this article, refuse to renew, suspend, or revoke a certificate of authority if the applicant or holder of the certificate of authority:

(1) violates any provision of this article other than one that provides for mandatory denial, refusal to renew, suspension, or revocation for its violation[.]

(d) Instead of or in addition to suspending or revoking a certificate of authority, the Commissioner may:

(1) impose on the holder a penalty of not less than $100 but not more than $125,000 for each violation of this article[.]

ORDER

WHEREFORE, for the reasons set forth above, it is **ORDERED** by the Commissioner and consented to by the Respondent**:**

A. That, pursuant to § 4-113 of the Insurance Article, based on consideration of COMAR 31.02.04.02 and the significant remediation efforts voluntarily undertaken by KPIC, the Administration imposes a penalty of $40,000 for the violations of § 15-112 of the Insurance Article and COMAR 31.10.44.03C identified here.

OTHER PROVISIONS

B. The executed Order and any administrative penalty shall be sent to the attention of: David Cooney, Associate Commissioner, Life and Health, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202.

C. For the purposes of the Administration and for any subsequent administrative or civil proceedings concerning Respondent, whether related or unrelated to the foregoing paragraphs, and with regard to requests for information about the Respondent made under the Maryland Public Information Act, or properly made by governmental agencies, this Order will be kept and maintained in the regular course of

business by the Administration. For the purposes of the business of the Administration, the records and publications of the Administration will reflect this Order.

D. The parties acknowledge that this Order resolves all matters relating to the factual assertions and agreements contained herein and are to be used solely for the purposes of this proceeding brought by or on behalf of the Administration. Nothing herein shall be deemed a waiver of the Commissioner's right to proceed in an administrative action or civil action for violations not specifically identified in this Order, including, but not limited to, specific consumer complaints received by the Administration, nor shall anything herein be deemed a waiver of the right of the Respondent to contest other proceedings by the Administration. This Order shall not be construed to resolve or preclude any potential or pending civil, administrative, or criminal action or prosecution by any other person, entity or governmental authority, including but not limited to the Insurance Fraud Division of the Administration, regarding any conduct by the Respondent including the conduct that is the subject of this Order.

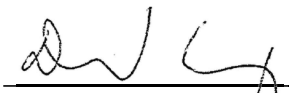
E. Respondent has had the opportunity to have this Order reviewed by legal counsel of its choosing, and is aware of the benefits gained and obligations incurred by the execution of the Order. Respondent waives any and all rights to any hearing or judicial review of this Order to which it would otherwise be entitled under the Insurance Article with respect to any of the determinations made or actions ordered by this Order.

F. This Order contains the entire agreement between the parties relating to the administrative actions addressed herein. This Order supersedes any and all earlier agreements or negotiations, whether oral or written. All time frames set forth in this Order may be amended or modified only by subsequent written agreement of the parties.

G. This Order shall be effective upon signing by the Commissioner or his designee, and is a Final Order of the Commissioner under § 2-204 of the Insurance Article.

H. Failure to comply with the terms of this Order may subject Respondent to further legal and/or administrative action.

Kathleen A. Birrane
INSURANCE COMMISSIONER



By: David Cooney
Associate Commissioner, Life & Health

Date: March 9, 2023

RESPONDENT'S CONSENT

RESPONDENT hereby CONSENTS to the representations made in, and to the terms of, the above Consent Order. On behalf of Respondent, the undersigned hereby affirms that he or she has taken all necessary steps to obtain the authority to bind Respondent to the obligations stated herein and does in fact have the authority to bind Respondent to the obligations stated herein.

Name: Chuck Bevilacqua

Signature: 

Title: SVP, Health Plan Product Service & Administration ; President, KPIC

Date: 3/6/2023