Wellfleet Insurance Company

West Virginia Network Adequacy Access Plan

With the Cigna OAP Network

Wellfleet Insurance Company (WIC) offers Student Health Insurance Plans (SHIP) to colleges and universities in West Virginia. WIC partners and contracts with the Cigna network to provide network services to our members at WV SHIP schools.

WIC files our WV SHIP Rate and Form filings in SERFF. Our Form filing includes a copy of the WV Policy and Certificate of Coverage that is provided to students at our WV SHIP schools.

The WIC SHIP Plans, Certificate of Insurance and Policies and Procedures include items required by West Virginia Network Plans and Adequacy H.B. 4061 and Legislative Rules, including but not limited to the following items.

Members can identify the Preferred Provider Network that is used on their Student Health Insurance Plan (SHIP) by looking at their Wellfleet ID Card as shown below on the ID card letter and ID card they receive from Wellfleet.

STUDENT SAMPLE
10 MAIN STREET
SPRINGFIELD, MA 01115

Important Information - Please Read Carefully

Thank you for participating in the Student Health Insurance Plan (SHIP) administered by Wellfleet Group, LLC.

Attached you will find your health insurance ID card. Please keep this card with you and always present it whenever you seek medical treatment in order to assure proper coverage for services. This card can be used for the entire term of your enrollment in the health plan. All claims should be forwarded to the address specified on your ID Card.

To learn about your Student Health Insurance Plan please visit www.wellfleetstudent.com, and select your school. We recommend you visit this site periodically to stay up to date on your plan. Your school page will provide you with important information such as:

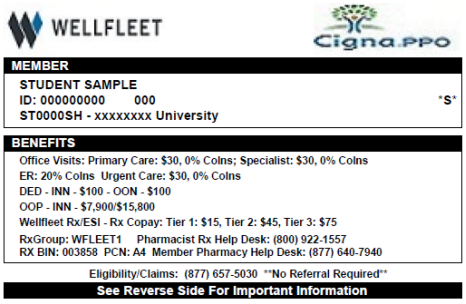
* Carrier Privacy Notices, Disclosures and Important Alerts
* Plan documents such as Benefits at a Glance and Certificates of Coverage
* Access to your electronic ID Card, claims information and Explanation of Benefits documents
* Links to a directory of Network Providers contracted to provide discounted rates for health care services
* Links to additional services such as pharmacy benefits and formularies, behavioral health counselors, nurse hotlines, and emergency travel assistance services (if included in your plan)
* Plus value added services such as discount dental and vision programs available to you as a Wellfleet member

We encourage you to create/access your account using the My Account link on the school page and verify/update your personal information by selecting the Student Options tab once you have signed in to the system.

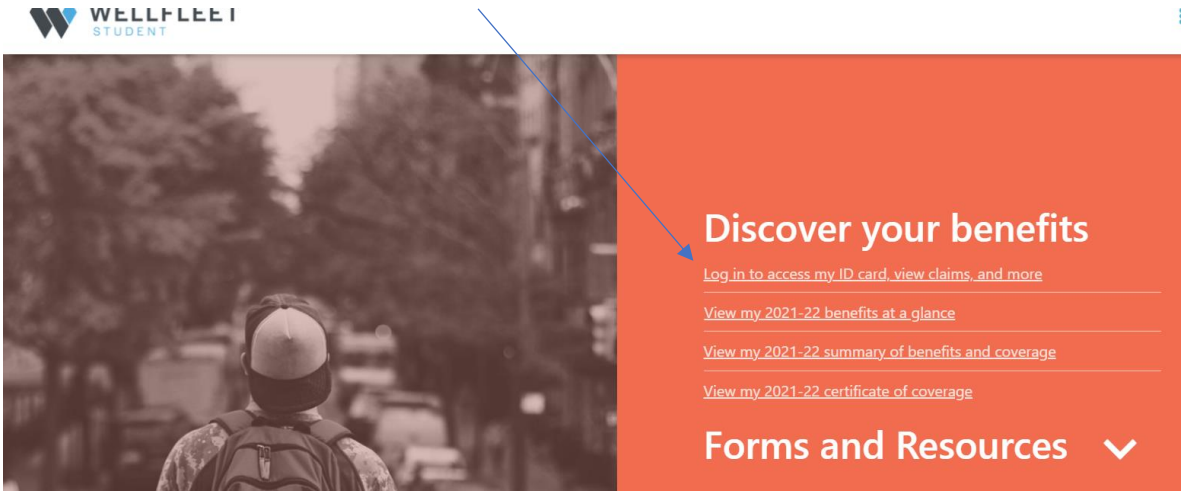
Please review the plan documents to understand the benefits and exclusions of your plan. You can reach us by using the Contact Us link on our website, by email at customerservice@wellfleetinsurance.com, or by phone at (877) 657-5030 with any questions you may have about your plan, its benefits, exclusions and claims.

Thank you for your participation and welcome to Wellfleet.

Cigna PPO is the Provider Network supporting your Student Health Insurance Plan.
Wellfleet Group, LLC is the Plan Administrator.
This plan is fully insured by Wellfleet Insurance Company.



Members can also access their ID card by logging into their secure Wellfleet Student Health Insurance Plan website on this URL. https://wellfleetstudent.com/



Wellfleet provides the following services:

- Customer Service
- Claims processing
- Member and Provider Appeals and Grievances

- Underwriting Services
- Issuance of policies
- Collection and administration of premiums
- Financial Reporting
- Regulatory Reporting
- Advertising and Sales
- Information technology services

The Cigna network provides the following network services and functions as shown below.

- Provider Credentialing and Recredentialing
- Provider Contracting
- Provider Claim Repricing
- Provider Directory Production and Updates
- Provider Availability and Accessibility
- Utilization Review

Network Access Plan Standards

W. Va. Code §33-55-3(f)(1) & W. Va. Legislative Rule §114-100-4.8.1:

A description of the network and how telemedicine, telehealth or other technology may be used to meet network access standards

Description of the Network

The WIC WV SHIP Certificate of Coverage provides access to a Preferred Provider Network. The plan provide access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Plan's Schedule of Benefits.

If members use an In-Network Provider, the Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits for Covered Medical Expenses.

If an Out-of-Network Provider is used, the Certificate will pay the percentage of the Usual and Customary Charge forCovered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Telemedicine/Telehealth or Technology to meet network access standards

Several Cigna in-network providers perform services via telemedicine virtual and phone visits. For in-network Cigna medical providers, the Cigna directories do not currently indicate which providers offer telehealth services. However, those providers would inform members of virtual visits when the member calls for an appointment.

For Cigna in-network Behavioral Health providers, the Cigna provider directory indicates those providers who offer telemedicine services. Telemedicine claims are repriced by Cigna based upon the coding submitted and federal/state guidance.

In addition, Wellfleet offers Telemedicine visits to our SHIP plans through an external telehealth vendor as a buy-up option, for plans that elect to purchase this option. Not all plans purchase the buy-up option. Members would see the buy-up option noted on their ID card if their plan elected these services.

W. Va. Code §33-55-3(f)(4) & W. Va. Legislative Rule §114-100-4.8.2

A description of each the factor used to build the provider network, including a description of the network and the criteria used to select providers.

Response:
Provider networks are open to any provider that is willing to join the network, meets credentialing criteria and agrees to contract terms. Providers applying are required to sign an agreement for participation, and complete the credentialing process prior to becoming a participating provider, and are re-credentialed within 36 months thereafter, to ensure they continue to meet our qualifications for participation. The criteria for participation is determined by business needs and by Cigna's credentialing policies and procedures, which is reviewed annually to reflect National Committee for Quality Assurance (NCQA), local, federal, and state standards and guidelines.

The credentialing process includes a review of the standard application and independent verification of certain documentation submitted. Information submitted must be accurate, current, and complete.

Requirements for credentialing include a completed signed and dated application, a completed, signed and dated authorization and release form (if not included in the application form), documented work history for the past 5 years (initial cred only), current unrestricted license to practice medicine, current unrestricted DEA certificate (if applicable), current unrestricted CDS certificate (if applicable), Board Certification (if applicable),verifiable education/training (if not board certified), unrestricted admitting privileges to at least one participating hospital (if applicable), current professional liability insurance with required minimum coverage, acceptable history of professional liability claim experience, acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory or other professional organization. Cigna confirms that the provider continues to be in good standing with state and federal regulatory bodies at the time of initial credentialing, re-credentialing and in between cycles, and, if applicable, is reviewed and approved by an accrediting body.

In addition, the below language is included in the Cigna Provider Network Directory.

How the Network is built/Description of the network/Provider Network Selection Criteria:
Cigna contracts with physicians, physician groups, associations and delivery systems, hospitals, ancillary practitioners, and facilities so that our customers can obtain the care they need at a more affordable cost. To build our networks, we look at how many primary and specialty care doctors are in a specific area. We also look at hospitals and other health care providers. This way we can make sure there are enough health care providers available to meet your health care needs so that you don't have to go a long way or spend a lot of time getting there. All doctors and hospitals must meet certain credentialing requirements and agree to rates with us before joining our network. We don't use measures related to quality, member experience, patient safety or cost to select providers.

Some health care providers share with Cigna or a third-party vendor the various languages spoken in their offices, and Cigna publishes that information in this directory. The languages listed are not guaranteed by Cigna and are not meant to meet any state or federal laws. Please call the health care provider to confirm the current languages spoken in their office.

Medical health care provider information addressing board certification, state licensure and hospital affiliations is obtained from an application that is completed and signed by the health care provider or facility during credentialing, as applicable. Physician board certification is verified through the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

W. Va. Legislative Rule §114-100-4.8.4,

A list of the specific provider and facility types within the Cigna OAP Network is included in the attached Exhibit A - Provider Types by County – Cigna OAP.

The Access Plan should address the Carrier's provision of a comprehensive listing of the participating providers and facilities to covered persons and primary care providers.

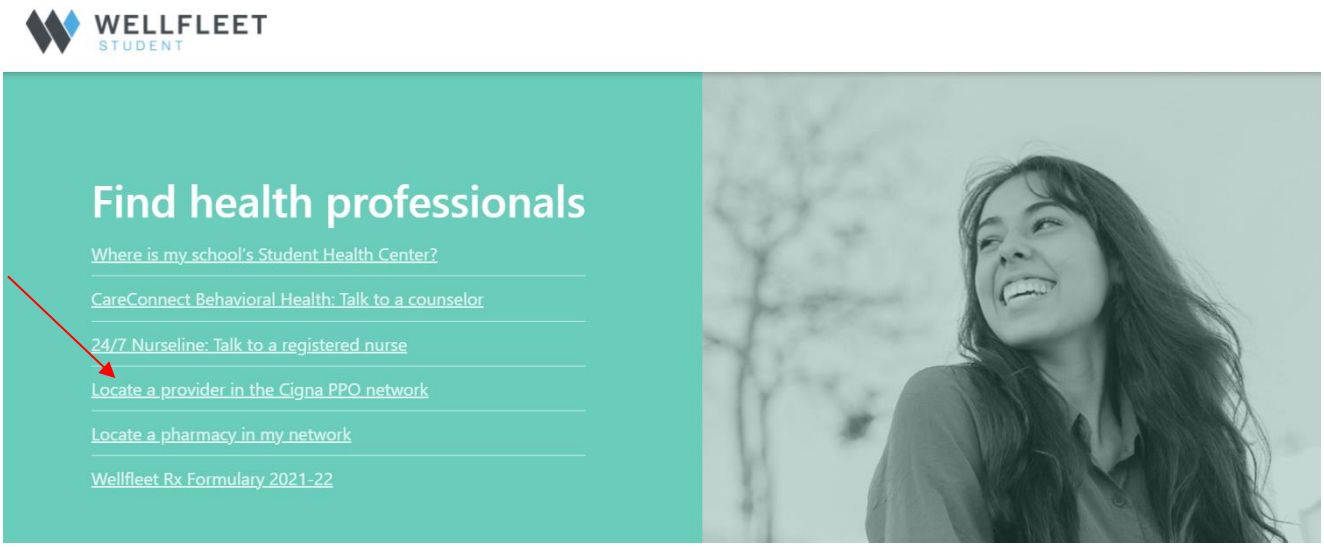
The below instructions and screen shots are added to the Wellfleet West Virginia Network Adequacy Access Plan; Cigna OAP Network version.

Instructions for how a member can locate a comprehensive listing of the participating providers and facilities to covered persons and primary care providers.

Wellfleet SHIP Students have access to their specific Wellfleet School Webpage which includes an abundant amount of information about their SHIP plan. The school webpage provides students with access to their ID card, a copy of the plan Policy and Certification of Coverage, links to locate in-network providers, etc. The website to access the school webpage is: https://wellfleetstudent.com/

A Members can click on the link noted below by the arrow and they are automatically linked to the Cigna online directory provider finder tool as shown in the below screen shots

Note: Below is what the school webpage with the Cigna network would look like when Wellfleet has a WV SHIP using the Cigna network.



The URL for covered persons to access the Cigna OAP provider directory is included below.

https://www.cigna.com/

W. Va. Code §33-55-3(f)(3) & W. Va. Legislative Rule §114-100-4.8.5:

A description of the documented, quantifiable and measurable process for monitoring and assuring the sufficiency of the network in order to meet the health care needs of covered persons on an ongoing basis.

Note: When Wellfleet writes a SHIP plan in WV with the Cigna network, we would work with Cigna to monitor the network including but not limited to, requesting GeoAccess reports to monitor provider to member ratios.

Wellfleet would provide our network partner with a list of WV SHIP members and our network partner would populate a Network Access Report which identifies the member to in network provider ratio report.

The network would provide a list of WV providers to WIC and WIC submits these lists to the WV Department of Insurance with our Network Access and Adequacy filing to ensure sufficiency of the network.

In addition, regarding Wellfleet's oversight of our network partners, Wellfleet has a formal Delegation Oversight Committee that monitors our vendor partners. A summary of our Delegation Oversight Committee is included below

Delegation Oversight Committee (DOC)

The DOC provides a forum for the review of all aspects of essential business activities at Wellfleet that are delegated to a subcontractor.

In this role, they:

- Assure the efficient collection of quality initiative-related data and its transformation into useful information.
- Review and evaluate the results of quality monitoring activities, studies, and surveys.
- Share action plans to ensure the consistency of activities and avoid duplication of effort.
- Identify, research, and recommend to the QMC:
  - quality improvement activities
  - key performance indicators
  - benchmarks and thresholds
  - assessment methods
  - corrective action plans to address identified problems
  - methods to monitor the implementation and effect of solutions, and
  - methods to evaluate materials prior to submission to the QMC.

Membership of this committee consists of (but not limited to) representation from Clinical, Pharmacy, Provider Relations, Legal, Claims, and Finance.

The DOC meets several times per year. Written minutes of meetings are maintained.

A delegation oversight tool is used to monitor vendor services and these oversight tools are presented to Wellfleet's Quality Program Management Committee and Executive Quality Program Management Committee at reoccurring Quality Program Meetings.

W. Va. Legislative Rule §114-100-4.8.6:

A description of the process to assure that a covered person is able to obtain a covered benefit, at the in-network benefit level, from a non-participating provider should the carrier's network be deficient.

The process for a covered person to obtain a covered benefit, at the in-network benefit level, from a non-participating provider is described below.

If a member needs to seek treatment from an out-of-network provider because there are no in network providers available to provide the required services, the member contacts the Wellfleet Member Service Team at the phone number located on their ID card. When a Wellfleet Customer Service Representative (CSR) receives one of these calls from a member, they follow the below process.

1. Confirm if the provider the covered person wants to receive care from, is or is not in the network used on the covered person's plan by accessing the online provider directory on the member's plan.

2. If CSR <u>can locate an in-network</u> provider, direct the member to the in-network provider, identify name and address of that in-network provider **and log that information in the member record using a specific call code.**

- If the provider identified by the member is not in network and there are no in network providers available within a reasonable distance and time (accepting new patients, if applicable), then Cust Serv Rep. will log the details of the call in the member record and add the specific member and provider specific demographic information.

3. If CSR has a question about the specific type of provider specialist that is needed to provide treatment to the member, CRS will email the details of the call to the Wellfleet Clinical Team for review.

3a. Clinical Team Rep. once reviewed, if the request is approved, the clinical team will send a letter to the member and document the member record and will notify the Claim Manager so she can add an alert code to the member's claim file so the claim can be reimbursed at the plans in-network benefit level.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage that supports this provision.

Preferred Provider Organization If You use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits for Covered Medical Expenses. If an Out-of-Network Provider is used, this Certificate will pay the percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider and will calculate Your cost sharing amount at the In-Network Provider level if:

1. there is no In-Network Provider in the service area available to treat You for a specific Covered Injury or Covered Sickness; or

2. there is an Emergency Medical Condition and You cannot reasonably reach an In-Network Provider; or

3. You receive services rendered by an Out-of-Network provider at an In-Network Provider facility during:

- A service or procedure performed by an In-Network Provider; or
- During a service or procedure previously approved or authorized by Us and You did not knowingly elect to obtain such services from the Out-of-Network provider.

You should be aware that In-Network Hospitals may be staffed with Out-of-Network Providers. Receiving services from an In-Network Hospital does not guarantee that all charges will be paid at the In-Network Provider level of benefits. It is important that You verify that Your Physicians are In-Network Providers each time You call for an appointment or at the time of service.

W. Va. Code §33-55-3(f)(2) & W. Va. Legislative Rule §114-100-4.8.7 (a-d:)

A description of the procedures for making and authorizing referrals within and outside its network.

Wellfleet Student Health Plans (SHIP) do not require a member to get a referral from a primary care doctor to see a specialist.

However, a written referral from some of the colleges and universities Student Health Center's (SHC) with Wellfleet SHIP insurance, is recommended for any follow-up care, with a Provider other than the SHC, after Emergency services. In these instances, a SHC referral does not constitute a guarantee of Benefits when Treatment is provided outside the SHC.

For Wellfleet plans that may include a referral from the SHC, there is no financial penalty to the student if they do not get a referral.

W. Va. Code §33-55-3(f)(9) & W. Va. Legislative Rule §114-100-4.8.8

A description of the process for enabling covered persons to change primary care professionals.

Wellfleet SHIP Plans do not require members to select a primary care provider or to notify the Plan when they seek treatment from a specialist or change to a different provider. Members may see any provider they desire and change providers at any time.

Below is the language that would be included in the Wellfleet West Virginia Explanation of Coverage when Wellfleet has a SHIP plan in WV. Members are free to select either an in or out of network provider.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
This Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

W. Va. Code §33-55-3(f)(6) & W. Va. Legislative Rule §114-100-4.8.10

A description of methods used to assess the health care needs of covered persons and their satisfaction with services.

Wellfleet members can contact the WIC customer service team at the telephone number on their ID card to provide satisfaction outcomes with the services they receive. In addition, Wellfleet will send an annual member satisfaction survey to members in West Virginia to assess their satisfaction with services when Wellfleet has WV SHIP Plans.

W. Va. Code §33-55-3(f)(5) & W. Va. Legislative Rule §114-100-4.8.11

A description of efforts made to address the needs of covered persons with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This should include efforts, to include various types of ECPs in its network.

Cigna would not evaluate the Wellfleet member population to address specific needs based upon 1) diverse cultural or ethnic backgrounds; 2) physical or mental disabilities; or 3) serious, chronic, or complex medical conditions.

Wellfleet provides a language assistance line for members who speak language other than English. Information regarding the language line is included on the Wellfleet website, in the Wellfleet Certificate of Insurance.

The below Disclosure is in included in the Wellfleet WV SHIP Certificate of Coverage that is available to covered members.

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact John Kelley Civil Rights Coordinator.

If you believe that Wellfleet Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

John Kelley Civil Rights Coordinator,
PO Box 15369
Springfield, MA 01115-5369
(413)-733-4612
Jkelley@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance John Kelley of Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

With respect to ECP recruitment efforts, there is an active, ongoing recruitment effort in West Virginia for ECPs. Cigna identifies ECPs via the Center for Medicare and Medicaid Services ("CMS") Non-Exhaustive list of ECP's which is updated annually. Based on these listings, Cigna actively recruits and extends contracts. All providers, including ECP's must meet contracting requirements such as reimbursement rates, and agree to contract language such as member hold harmless agreements.

W. Va. Code §33-55-3(f)(7)(A) & W. Va. Legislative Rule §114-100-4.8.12. a

A description of methods used to inform covered persons of the plan's grievance and appeal procedure.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage.

SECTION [X] – APPEALS PROCEDURE

If You have a claim that is denied by Us, You have the right to appeal it. Your Authorized Representative may act on Your behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination.

For purposes of this Section, the following definitions apply:

Adverse Benefit Determination means:

• A determination by Us [or Our designee Utilization review organization] that, based upon the information provided, a request for a benefit under the Policy upon application of any utilization review technique does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental

or Investigative and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

- The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by Us [or Our designee Utilization review organization] of Your eligibility under the Policy;

- Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit; or

- A rescission of coverage.

Authorized Representative means:

- A person to whom have given express written consent to represent You;

- A person authorized by law to provide substituted consent for You;

- A family member of Yours or Your treating health care professional when You are unable to provide consent;

- A health care professional when the Policy requires that a request for a benefit under the Policy be initiated by the health care professional; or

- In the case of an Urgent Care claim, a health care professional with knowledge of Your medical condition.

Concurrent claim means a request for a plan benefit(s) by You that is for an ongoing course of treatment or services over a period of time or for the number of treatments.

Concurrent review means Utilization review conducted during a patient's stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Health care professional means a Physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Pre-service claim means the request for a plan benefit(s) by You prior to a service being rendered and is not considered a concurrent claim.

Post-Service Claim means any claims for a plan benefit(s) that is not a Pre-Service Claim.

Prospective review means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with Our requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Retrospective review means any review of a request for a benefit that is not a prospective review request. Retrospective review does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Urgent Care request means a request for a health care service or course of Treatment with respect to which the time periods for making a non-urgent care request determination:

1.

a. Could seriously jeopardize Your life or health or Your ability to regain maximum function; or

b. In the opinion of a Physician with knowledge of Your medical condition, would subject You to severe pain that cannot be adequately managed without the health care service or Treatment that is the subject of the request.

2.

a. Except as provided in (b) of this paragraph, in determining whether a request is to be treated as an Urgent Care request, an individual acting on Our behalf shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

b. Any request that a Physician with knowledge of Your medical condition determines is an Urgent Care Request shall be treated as an urgent care request.

Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the Medical Necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, Prospective review, second opinion, certification, Concurrent review, case management, discharge planning or Retrospective review.

[Utilization review organization means an entity that conducts Utilization review, other than Us performing utilization review for Our own health benefit plans.]

There are 3 types of claims: Pre-Service, Concurrent Care, and Post-Service Claims. In addition, certain Pre-Service or Concurrent Care Claims may involve Urgent Care. If the Company makes an Adverse Benefit Determination, then You may appeal according to the following steps.

Step 1:

If Your claim is denied, You will receive written notice from Us that Your claim is denied (in the case of Urgent Claims, notice may be oral). The period in which You will receive this notice will vary depending on the type of claim.

In addition, we may take an extension of time in which to review Your claim for reasons beyond Our control. If the reason for the extension is that You need to provide additional information, You will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The period during which We must make a decision will be suspended until the earlier of the date that You provide the information or the end of the applicable information gathering period.

Type of Claim	**You will be notified by Us that a claim is denied as soon as possible but no later than:**	**Extension period allowed for circumstances beyond Our control:**	**If additional information is needed, You must provide within:**
Pre-Service Claim	15 days from receipt of claim (whether adverse or not)	One extension of 15 days	45 days of date of extension notice
Pre-Service Claim involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)

Concurrent: To end or reduce Treatment prematurely (other than by policy amendment or termination) Pending the outcome of an appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	Notification to end or reduce Treatment will allow sufficient time in advance to allow You to appeal and obtain a determination on the adverse benefit determination prior to the end or reduction of prescribed Treatment	N/A	N/A
Concurrent: To deny Your request to extend Treatment	30 days from receipt of claim for Pre-Service Claim; or 60 days from receipt of claim for Post-Service Claim	On extension of 15 days	45 days of the date of extension notice
Concurrent: Involving Urgent Care	72 hours from receipt of claim (whether adverse or not) (24 hours after receipt of claim if additional information is needed from You; or 24 hours after receipt of claim provided that any such claim is made at least 24 hours prior to the end or reduction of prescribed Treatment)	None	48 hours (We must notify You of determination within 48 hours of receipt of Your information)

Post-Service Claim	30 days from receipt of claim	One extension of 15 days	45 days of the date ofextension notice

Once You have received notice from Us, You should review it carefully. The notice will contain:

1. The reason(s) for the denial and the Policy provisions on which the denial is based.
2. A description of any additional information necessary for You to perfect Your claim, why the information is necessary, and Your time limit for submitting the information.
3. A description of the Policy's appeal procedures and the time limits applicable to such procedures, including a statement of Your right to bring a civil action following a final denial of Your appeal.
4. A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and astatement that a copy of that rule, guideline or protocol will be made available upon request free of charge.
5. If the denial is based on a Medical Necessity, experimental Treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
6. If the claim was an Urgent Care request, a description of the expedited appeals process. The notice may be provided to You orally within 72 hours; however, a written or electronic notification will be sent to You no later than 3 days after the oral notification. If the claim was/is an Urgent Care request, You may initiate an Internal Appeal and an External Review simultaneously.
7. Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).
8. An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).
9. The contact information for all relevant review agency contacts and the office of health insurance consumer assistance to assist You with Your claims, appeals and external review.
10. Notification that culturally and linguistically appropriate services are available.

INTERNAL APPEAL

Step 2:

If You do not agree with Our decision and wish to appeal, You must file a written appeal with Us at the address below within 180 days of receipt of the notification (or oral notice if an Urgent Care request) referenced in Step 1. If the claim involves Urgent Care, Your appeal may be made orally.

You should submit all information referenced in Step 2 with Your appeal. You should gather any additional informationthat is identified in the notice as necessary to perfect Your claim and any other information that You believe will support Your claim.

Appeals should be sent to:
Wellfleet Insurance Company
Attention: Appeals Unit
PO Box 15369
Springfield, MA 01115-5369

Type of Claim	You must file Your appeal within:	You will be notified of Our determination as soon as possible but no later than:
Pre-Service Claim	180 days of claim denial	15 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days of claim denial	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	Notification will specify filing limit. Notification to end or reduce Treatment will allow sufficient time to finalize appeal before end of Treatment	15 days of receipt of appeal
Concurrent: To deny Your request to extend Treatment	180 days of claim denial for Pre-Service or Post-Service Claim	15 days of receipt of appeal for Pre-Service Claim; or 30 days of receipt of appeal for Post-Service Claim
Concurrent: Involving Urgent Care	180 days of claim denial	72 hours of receipt of appeal
Post-Service Claim	180 days of claim denial	30 days of receipt of appeal

Step 3:

If Your appeal is denied based on medical judgement such as Medical Necessity, appropriateness, health care setting, levelof care or effectiveness of the health care service or Treatment and You wish to seek an external review from an Independent Review Organization (IRO), You must file a written request for external review.

You may also seek an external review by an IRO for a denial of an Urgent Care request based on medical judgement provided that (1) You have also filed an internal appeal in accordance with the terms described herein; and (2) the time frames for completion of an Urgent Care appeal will seriously jeopardize Your life or health or would seriously jeopardizeYour ability to regain maximum function.

You may also seek an external review for a rescission of coverage.

STANDARD EXTERNAL REVIEW

Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination, You may file a request for an external review with Us or the West Virginia Commissioner of Insurance.

You must file Your written request for an external review with Us at the address below within 4 months of the date You received the applicable denial.

Within 5 business days of receiving Your request for an external review, We will complete a preliminary review of the request to determine whether You were covered under the Policy at the time the expense was incurred and whether You have exhausted the Internal Appeal process where required.

In most cases, You should complete Our Internal Appeals process before You:

- Contact the West Virginia Department of Insurance to request an investigation of a claim determination or appeal;
- File a complaint or appeal with the West Virginia Department of Insurance;

- File a request for an External Review;
- Pursue arbitration, litigation or other type of administrative proceedings.

However, in some cases, You do not have to exhaust the Internal Appeal process before You move on to an External Review. These situations are:

- We waive the Internal Appeal process;
- You have an Urgent Care situation or a claim that involves ongoing treatment. In these situations, You may haveYour claim go through the External Review at the same time as the Internal Appeal process; and
- We did not follow all of the State or Federal claim determination and appeal requirements. However, You willnot be able to proceed directly to an External Review if:
    - The rule violation was minor and not likely to influence a decision or harm You;
    - The violation was for a good cause or a matter beyond Our control;
    - The violation was part of an ongoing good faith exchange of information between You and Us.

Within 1 business day of making a determination, You will be notified if the external review request is denied and You will be provided with: (1) the reasons why the claim is initially ineligible for external review; or (2) the information or materials needed for a complete request. In the event Your request is denied due to lack of information or materials, Youmust perfect Your claim by the later of the end of the 4-month period following the final internal Adverse Benefit Determination or 48 hours following notification that Your request for external review was denied.

If initially eligible for an external review, We will assign the request to an IRO. The IRO will make a determination and provide You and Us with notice of its determination within 45 days of receiving the review request.

EXPEDITED EXTERNAL REVIEW

If, due to Your medical condition, the time frame for completion of the standard external review process would seriouslyjeopardize Your life or health or Your ability to regain maximum function, You may request an expedited external review,the preliminary review will be completed immediately. If determined to be initially eligible, We will assign the request toan IRO and the IRO will complete the review as expeditiously as Your medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to You orally, a written or electronic notification will be sent to You no later than 48 hours after the oral notification.

IMPORTANT INFORMATION

- Each level of appeal will be independent from the previous level (i.e., the same person(s) involved in a prior levelof appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that You submit even if it is new information. In addition,You have the right to request documents or other records relevant to Your claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health careprofessional that has expertise in the specific area involving medical judgment.
- You may review the claim file and present evidence and testimony at each state of the appeals process.
- You may request, free of charge, any new or additional evidence considered, relied upon, or generated by Us inconnection with Your claim.
- If a decision is made based on new or additional rationale, You will be provided with the

rationale and be given areasonable opportunity to respond before a final decision is made.

- If You wish to submit relevant documentation to be considered in reviewing Your claim for appeal, it must besubmitted with Your claim and/or appeal.
- You should exhaust these appeals procedures before filing a complaint or appeal with the West VirginiaDepartment of Insurance.
- You should raise all issues that You wish to appeal during Our Internal Appeal process and during the ExternalReview.

CONTACT INFORMATION

If you have any questions or concerns, You can contact Us at:
Wellfleet Insurance Company
Attention: Appeals
PO Box 15369
Springfield, MA 01115

West Virginia Offices of the Insurance Commissioner
P.O. Box 50540
900 Pennsylvania Avenue

Charleston, WV 25305
Phone: (888) 879-9842 or (304) 558-3386
Fax: (304) 558-4965

W. Va. Code §33-55-3(f)(7)(B) & W. Va. Legislative Rule §114-100-4.8.12.b

A description of methods used to inform covered persons of the process for choosing and changing providers.

When Wellfleet does write a SHIP Plan in WV, the below is the language that will be included in the Wellfleet West Virginia Explanation of Coverage. Members are free to select either an in or out of network provider.

Medical Benefit Payments for In-Network Providers and Out-of-Network Providers
This Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. This Certificate provides access to both In-Network Providers and Out-of-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers versus Out-of-Network Providers, as shown in the Schedule of Benefits.

W. Va. Code §33-55-3(f)(7)(C) & W. Va. Legislative Rule §114-100-4.8.12.c

A description of methods used to inform covered persons of the process for updating provider directories.

The following are screen shots from the printed and electronic directory samples showing how to report inaccurate information:

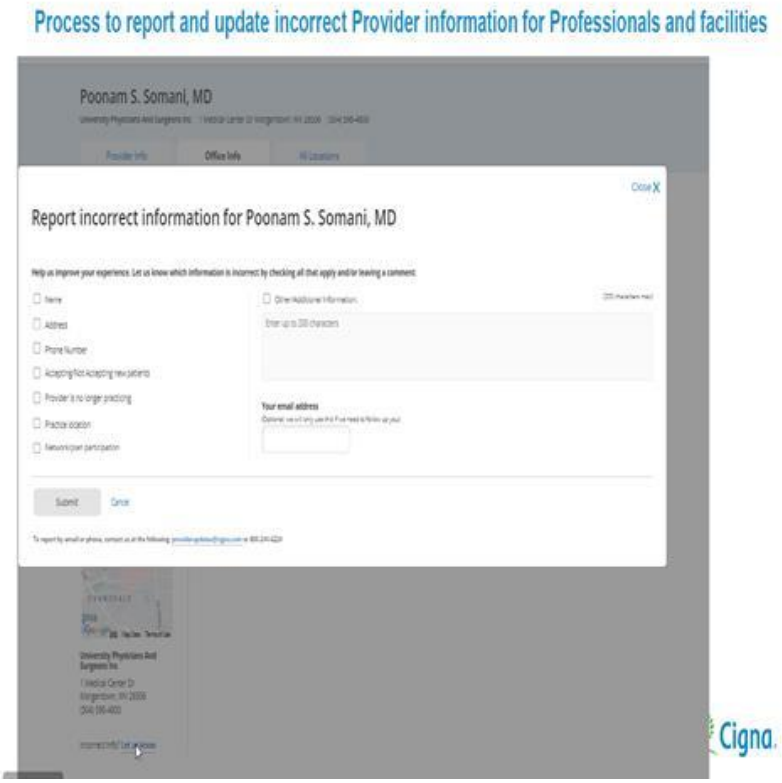
PRINT:

REPORT INACCURATE INFORMATION

If you see inaccurate information for a health care provider (HCP), please help us improve your experience by reporting it using one of the following options:

Report by phone: Call 800.244.6224
Report by e-mail: Send an e-mail to providerupdates@cigna.com and include the following:
Name, address and specialty of the HCP as it's currently displayed (this allows us to identify the HCP you are referencing), and information you believe is inaccurate, such as name (spelling), address, phone number, whether they are accepting new patients, or their participation in a certain network or benefit plan. Cigna will verify the information you have sent and ensure it is corrected accordingly.

ELECTRONIC:



W. Va. Code §33-55-3(f)(7)(D) & W. Va. Legislative Rule §114-100-4.8.12.d

A description of methods used to inform covered persons of health care services offered, including those services offered through the preventive care benefit.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage.

COVERED MEDICAL EXPENSES

We will pay for the following Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness.

Preventive Services

The following services shall be covered without regard to any Deductible, Coinsurance or Copayment requirement that would otherwise apply when provided by an In-Network Provider:

3. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).
4. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention.
5. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
6. With respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
7. Prostate screening exam and prostate specific antigen (PSA) test for males over age 50 – one per Policy Year.
8. Annual kidney disease screening and laboratory testing; including any combination of blood pressure testing, urine albumin or urine protein testing, and serum creatinine testing.

9. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are covered under the Prescription Drug Benefit. See Prescription Drugs for information on those services and devices.

Important Notes:

3. These Preventive Services recommendations and guidelines may be updated periodically. When these are updated, they will be applied to this plan. The updates will be effective on the first day of the calendar year, one year after the updated recommendation or guideline is issued.
4. Diagnostic testing for the treatment or diagnosis of a Covered Injury or Covered Sickness will not be covered under the Preventive Services. For those types of tests and Treatment, You will pay the cost sharing specific to Covered Medical Expense for diagnostic testing and Treatment.
5. This plan will not limit gender-specific Preventive Services based on Your gender at birth, Your identity, or according to other records.

To learn what frequency and age limits apply to routine physical exams and routine cancer screenings, contact Your Physician or contact Us by calling the number on Your ID card. This information can also be found at the [https://www.healthcare.gov/] website.

We may use reasonable medical management techniques to determine the frequency, method, Treatment, or setting of Preventive Services benefits when not specified in the recommendations and guidelines of the:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (ACIP)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration (HRSA)
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for
  children and adolescents

W. Va. Code §33-55-3(f)(7)(E) & W. Va. Legislative Rule §114-100-4.8.12.e

A description of methods used to inform covered persons of procedures for covering and approving emergency, urgent, and specialty care.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage:

Emergency Medical Condition means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

Preferred Provider Organization

If You use an In-Network Provider, this Certificate will pay the Coinsurance percentage of the Negotiated Charge for Covered Medical Expenses shown in the Schedule of Benefits for Covered Medical Expenses.

If an Out-of-Network Provider is used, this Certificate will pay the percentage of the Usual and Customary Charge for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be Your responsibility.

Note, however, that We will pay at the In-Network level for Treatment by an Out-of-Network Provider and will calculate Your cost sharing amount at the In-Network Provider level if:

1. there is no In-Network Provider in the service area available to treat You for a specific Covered Injury or Covered Sickness; or
2. **there is an Emergency Medical Condition and You cannot reasonably reach an In-Network Provider; or**
3. [You receive services rendered by an Out-of-Network provider at an In-Network Provider facility during:

• A service or procedure performed by an In-Network Provider; or

• During a service or procedure previously approved or authorized by Us and You did not knowingly elect to obtain such services from the Out-of-Network provider.]

Pre-Certification is not required for an **Emergency Medical Condition** or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage Benefit Amendment.

Emergency Services only in connection with care for an Emergency Medical Condition as defined. Benefits will be paid for the use of the emergency room, including services and supplies. Refer to the Emergency Ambulance Service provision for transportation coverage.

Payment of this benefit will not be denied based on the final diagnosis following stabilization.

In case of a medical emergency:

When You experience an Emergency Medical Condition, You should go to the nearest emergency room. You can also dial 911 or Your local emergency response service for medical and ambulance assistance. If possible, call Your Physician but only if a delay will not harm Your health.

2. **The Urgent Care Centers** benefit coverage description appearing in the Outpatient Benefits section is hereby deleted and replaced with the following:
   Urgent Care Centers (non-life-threatening conditions) for services provided at an Urgent Care Center, as shown in the Schedule of Benefits. In the case of a life-threatening condition, You should go to the nearest emergency room.

W. Va. Code §33-55-3(f)(11) & W. Va. Legislative Rule §114-100-4.8.14

A description of the process for monitoring access to physician specialist services in emergency room care, anesthesiology, radiology, hospitalist care, and pathology/laboratory services at their participating hospitals.

The Cigna Hospital Agreement (pages 8 and 9) include the relevant language related to this requirement.

Hospital-Based Physicians. Prior to the Effective Date and on or before each anniversary of this Agreement, Hospital will provide Cigna with a list of all hospital-based physicians and physician groups who render services to Hospital patients, including but not limited to, those who provide physician services to Hospital patients in the specialty areas of anesthesiology, radiology, pathology, emergency medicine, neonatology, perinatology, cardiology and intensive care (the "Hospital-Based Physicians"). Such list shall include the name of the group with which the physician is associated (if applicable) and the tax identification number utilized for payment of such physician's services. Hospital shall promptly notify Cigna of any changes to the information on such list. Reimbursement for those Hospital-Based Physicians that are employed by or compensated by Hospital is included in the rates set forth in Exhibit A, and Hospital shall be solely responsible for any amounts owing to such physicians for Covered Services above the amounts payable to Hospital under this Agreement. With respect to those Hospital-Based Physicians who are not employed by or compensated by Hospital, Hospital will require such physicians to obtain participating provider contracts with Cigna. Cigna reserves the right to revisit the level of reimbursement under this Agreement if the participation level of Hospital-Based Physicians with Cigna is detrimental to Cigna's cost and market competitiveness in Hospital's market area.

The local network contracting team is responsible for contracting with hospital-based physicians. There is a variety of ways in which the team monitors the participation status of these types of providers. The team reviews quarterly non-par spend reports to ensure that these groups are contracted. If groups are on the list that are not contracted, then contracts are offered to the groups. Additionally, during negotiations with hospitals, the team reviews their list of hospital-based providers and ensures that they are participating providers. If not, then they ask for assistance from the hospital to bring them in network. Each participating hospital in our network has an assigned contractor and it is that contracting team member's responsibility to ensure that these groups are contracted. Hospital-Based Physician contracting is also monitored at a national level by our Contract Review Committee. Occasionally, Hospital-Based Physician

groups refuse to contract, usually because they are not willing to accept reimbursement rates that are generally accepted by similar providers in the geography. Additionally, there are some hospital-based groups that are part of larger national entities that have historically been difficult to bring in network.

W. Va. Legislative Rule §114-100-4.8.9

A description of the quality assurance standards to identify, evaluate and remedy problems relating to access, continuity and quality of care.

Wellfleet has a formal Quality Management Program. "The Purpose", "Goals" and "Objectives" of our program is included below.

PURPOSE

The Quality Management Program *(hereafter referred to as "QM Program")* provides a formal process by which *Wellfleet, inclusive of Wellfleet Insurance Company, Wellfleet New York Insurance Company, and Wellfleet Group, LLC, ("Wellfleet)* along with its servicing partners and vendors, strives to continuously improve the level-of-care and service rendered to students, members and customers. It uses objective and subjective indicators to measure and evaluate the quality and safety of clinical services provided to members. The QM Program addresses medical care, behavioral health (BH) care, pharmacy services and the degree to which they are coordinated. It defines the systematic approach used to identify, prioritize, and pursue opportunities to improve services, and to resolve identified problems. The QM Program is reviewed, updated, and approved by the Executive Management Team and forwarded to the Board of Directors at least annually. It is distributed to applicable regulatory bodies and other stakeholders, as requested.

GOALS

The goals of the QM Program are to:

- Define, demonstrate, and communicate the organization-wide commitment to and involvement in achieving improvement in the quality of clinical and BH care and service for Wellfleet students/members/customers.
- Enhance the quality, appropriateness, availability, accessibility, safety, coordination, and continuity (across settings and transitions of care) of clinical and BH care (focusing on recovery, resiliency, and rehabilitation), and the quality of member services provided by Wellfleet and its servicing partners and those entities to which Wellfleet may delegate activities.
- Ensure relevance of activities through a thorough understanding of the Student Health Insurance Plans (SHIPs) demographics, and quality of care.
- Conduct operations in a manner that protects the confidentiality and dignity of all students/members/enrollees and respects their rights and cultural and linguistic diversity.
- Maintain compliance with Wellfleet standards as well as local, state, and federal laws, and requirements and/or accrediting agencies with which Wellfleet participates; and,
- Employ the continuous quality improvement philosophy and techniques on a SHIP-wide basis.

OBJECTIVES

Specific QM Program objectives have been developed to guide quality improvement activities. The objectives of the QM Program, as approved by the Executive Quality Management Committee and reported to the Board of Directors, are as follows.

- To continuously improve the caliber and delivery of clinical and administrative services to Wellfleet customers through systematic monitoring of critical performance indicators, identifying barriers to improvement, and implementing specific strategies to improve processes and outcomes.
- To annually evaluate the efficiency and effectiveness of the QM Program, including its structure, methodology, and results.
- To evaluate at least annually the efficiency and effectiveness of performance from any subcontracted agents or service providers, also known as delegated entities.
- To assure that all members are treated with dignity and respect, and are provided with appropriate, understandable education and information to accept responsibility and actively participate in personal health care decisions.
- To use evidence-based guidelines as the basis for all clinical decision-making.
- To support public health goals, as appropriate for the populations served, by integrating them into clinical quality improvement activities.
- To maintain regulatory compliance related to Wellfleet quality assurance and performance improvement activities.
- To identify disparities in health care delivery to members and intervene to reduce them by delivering culturally and linguistically appropriate care and services.

A copy of Wellfleet Insurance Company's Quality Management Program Document is available on the Wellfleet website on this link: https://wellfleetstudent.com/forms/. A snip of the website page to access the Quality program is shown below.

QUALITY MANAGEMENT

Wellfleet works hard to make our student experience with our health plans meet our members' healthcare needs. We aim to do this by measuring, monitoring, and improving clinical care and quality of service. The Wellfleet Quality Management Program and Evaluation Documents include the process and procedures we use to monitor the effectiveness of our quality program and outline some of the programs we use to improve quality.

For additional information or to request a copy of the Wellfleet Quality Management Program Description or Quality Evaluation Documents, please contact the Wellfleet Member Services team at 877-657-5030 or **via email**.

In addition, see below Cigna response.

Quality Program Scope
Cigna's Quality Program provides direction and oversight for the coordination of both quality improvement and quality management activities operationalized across the departments, matrix partners, health service affiliates, and delegates. The Program outlines quality-monitoring standards, promotes communication across departments, outlines quality-monitoring standards, monitors results to ensure achievement of the established goals, and provides guidance in initiating process improvement initiatives when opportunities
are identified. Quality Improvement Projects are designed and documented to objectively and systematically monitor, evaluate, and improve the quality, customer safety, and appropriateness of care and service.

Quality Program Measurement Activities
- Reviewing performance against key indicators as specifically identified in the quality work plan or quality committee scorecards.
- Evaluating satisfaction information, including survey data and complaint and appeal analysis.
  - Evaluating access to services provided by the utilization and case management program.
  - When network products are purchased:

o Promotion of quality clinical care and service, including both inpatient and outpatient services, provided by providers.
o Evaluating access to services.

W. Va. Legislative Rule §114-100-5.1

A description of the process for ensuring the coordination and continuity of care for its covered persons.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage:

Continuity of Care
If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 60 days from the date of the notice to You of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pre nancy. The transitional period must extend through the provision of postpartum
care directly related to the pregnancy.

W. Va. Code §33-55-3(f)(8)(A) & W. Va. Legislative Rule §114-100-5.2.1
A description of the process used to ensure coordination and continuity of care for covered persons referred to specialty physicians.

Wellfleet SHIP Plans do not require members to select a primary care provider or to notify the Plan when they seek treatment from a specialist or change to a different provider. Members may see any provider they desire and change providers at any time. Some colleges or university Student Health Centers may require student to see providers at the SHC prior to seeing a specialist. For plans that have this requirement, it is outlined in the Certificate of Insurance.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage

Continuity of Care
If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 60 days from the date of the notice to You of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pre nancy. The transitional period must extend through the provision of postpartum
care directly related to the pregnancy.

W. Va. Legislative Rule §114-100-5.2.4.

A description of the process for enabling covered persons to change primary care providers during the period of continuity of care.

Wellfleet SHIP Plans do not require members to select a primary care provider or to notify the Plan when they seek treatment from a specialist or change to a different provider. Members may see any provider they desire and change providers at any time. Some colleges or university Student Health Centers may require student to see providers at the SHC prior to seeing a specialist. For plans that have this requirement, it is outlined in the Certificate of Insurance.

The below language is included in Wellfleet's WV SHIP Certificate of Coverage

Continuity of Care

If You are undergoing an active course of Treatment with an In-Network Provider, You may request continuation of Treatment by such In-Network Provider in the event the In-Network Provider's contract has terminated with the Preferred Provider organization. We shall notify You of the termination of the In-Network Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining an alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 60 days from the date of the notice to You of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pre nancy. The transitional period must extend through the provision of postpartum
care directly related to the pregnancy.

W. Va. Code §33-55-3(f)(10) & W. Va. Legislative Rule §114-100-4.8.13 & 5.2.5

A description of the plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations.

The below language is included in the Provider Network Agreement:

(b) Upon termination of this Agreement for any reason or termination of any Network in which Participating Professional participates, Participating Professional will:

(i) continue to provide health care services to Participants who are receiving treatment on the effective date of termination (1) until the course of treatment is completed; (2) for a period of ninety (90) days or through the current period of active treatment for those Participants undergoing active treatment for a chronic or acute medical condition, whichever time period is shorter; (3) throughout the second and third trimester of pregnancy and/or through postpartum care, if requested by the Participant; or (4) until Participating Professional makes reasonable and medically appropriate arrangements to transfer the Participant to the care of another provider, making such transfer to a Network Provider whenever appropriate (except as specified in subsections (2) and
(3) herein);

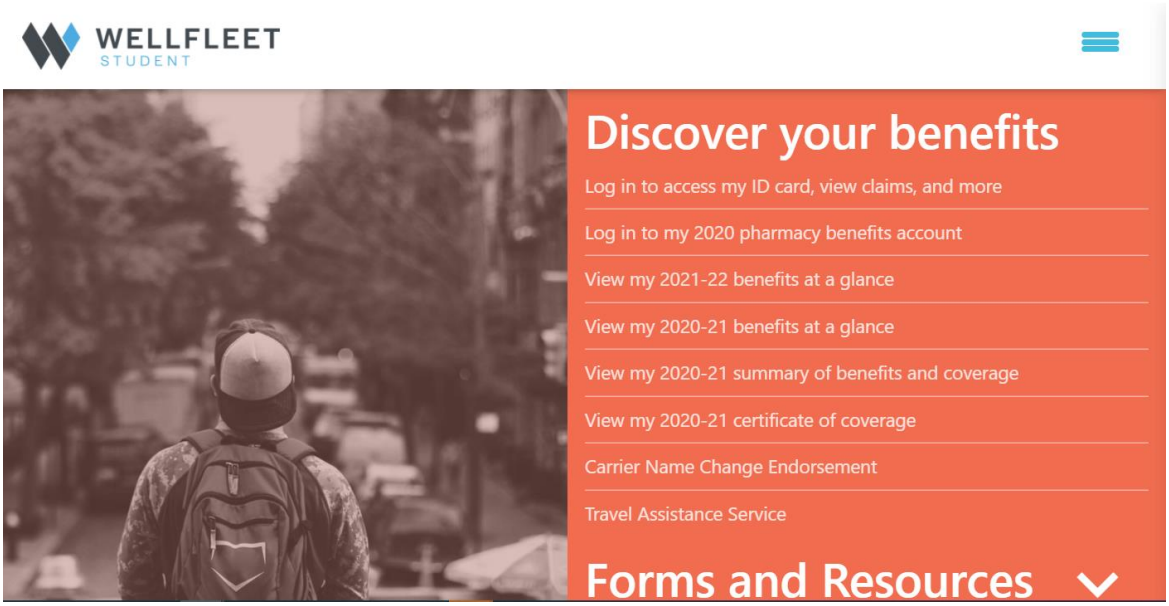
(ii) accept payment made pursuant to Article V, as payment in full, for Covered Services rendered in accordance with this Section; and

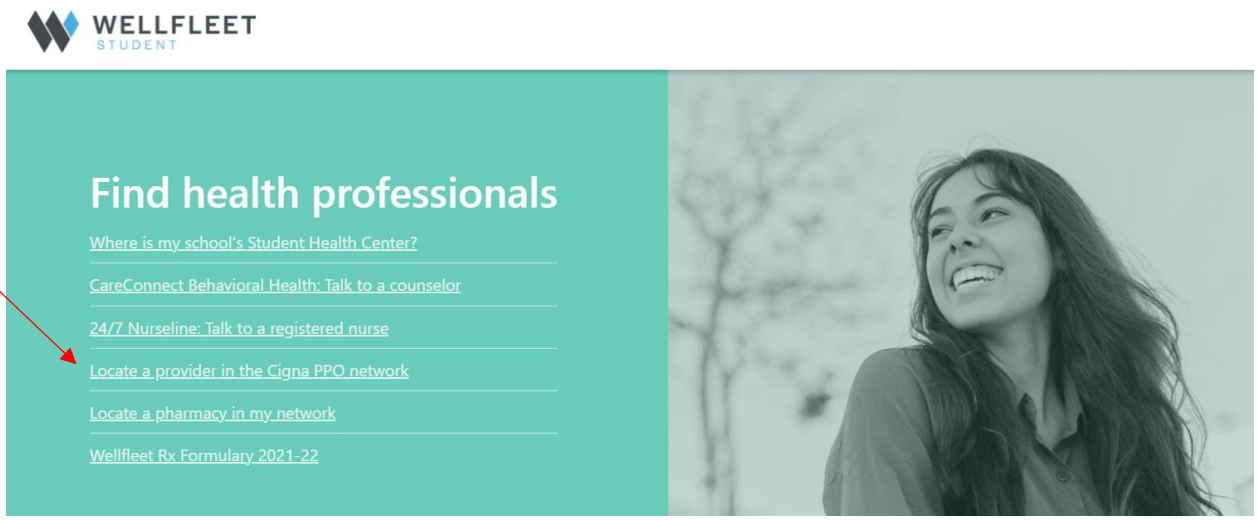
(iii) inform Participants seeking health care services that Participating Professional is no longer a Network Provider.

How to Locate Information About the Wellfleet Student Health Insurance Plan:

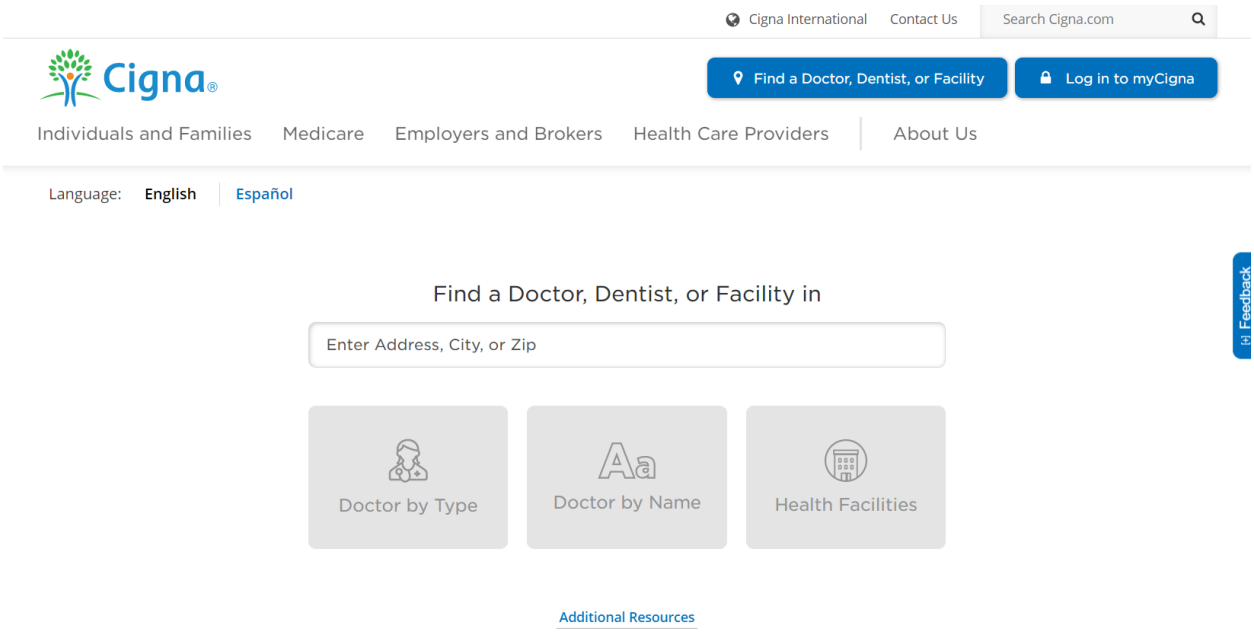
WIC SHIP Students also have access to their specific Wellfleet School Webpage which includes an abundant amount of information about their SHIP plan. The school webpage provides students with access to their ID card, a copy of the plan Policy and Certification of Coverage, links to locate in-network providers, etc. The website to access the school webpage is: https://wellfleetstudent.com/

Screen shots of the school webpage is shown below.





To find a network provider, members would click on the link noted above by the arrow and it would open to the Cigna provider finder home page as shown below.



In addition, WIC members can contact Wellfleet for questions and inquiries about their plan as shown on their ID card.

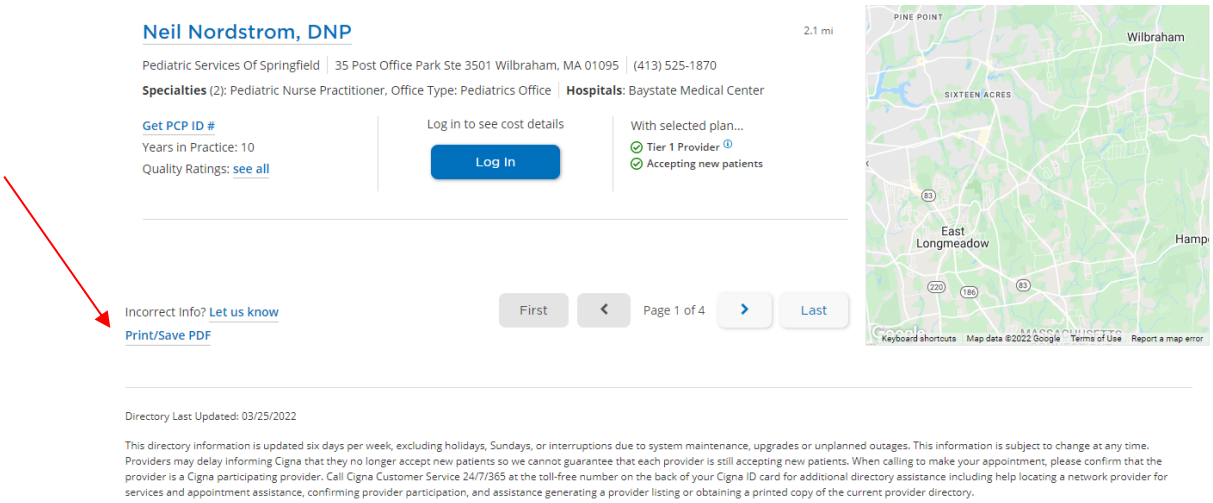
W. Va. Code §33-55-3(f)(12) and W. Va. Legislative Rule §114-100-7, include the exact URL location provided to covered personsand potential covered persons to access the Carrier's provider directory.

The URL for covered persons to access the provider directory is included below.

https://www.cigna.com/

W. Va. Code §33-55-3(f)(12) and W. Va. Legislative Rule §114-100-7, information how members can obtain printed directories

A directory can be printed by clicking on the Print/Save PDF link in the online directory as shown below.



Instructions for how a member can locate a comprehensive listing of the participating providers and facilities to covered persons and primary care providers.

WIC SHIP Students have access to their specific Wellfleet School Webpage which includes an abundant amount of information about their SHIP plan. The school webpage provides students with access to their ID card, a copy of the plan Policy and Certification of Coverage, links to locate in-network providers, etc. The website to access the school webpage is: https://wellfleetstudent.com/

Members can access the provider directory on the URL noted above. Once the member selects the "Find a Provider" link on the URL, and selects the network name then inputs their zip code and type of provider they would like to locate, they can click on the "Print/Save PDF" link to print the directory

W. Va. Legislative Rule §114-100-7.4. Provider Directory Audits

Cigna works diligently to ensure its provider directories are of the highest quality. In 2021, Cigna implemented an annual directory audit of 100% of WV providers to comply with how it interpreted the regulation. The 2021 audit included over 12,000 WV providers and represented 100% of providers displayed in Cigna's directory. Furthermore, Cigna will be performing provider directory audits every 90 days to comply with new federal regulation, which is in addition to the WV annual 100% provider directory audit.

West Virginia Insurance Bulletin 22 – 01.

Provide a detailed explanation and substantiating documentation regarding how it meets the requirements of the federal No Surprises Act as addressed under West Virginia Insurance Bulletin 22 – 01.

To meet the requirements of the Federal No Surprises Act, Wellfleet created and filed a Policy/Certificate Amendment which includes the required elements of the Act. A snapshot of the specific language in the Policy/Certificate Amendment is included below.

Wellfleet also created a notice that includes the member's rights and protections against Surprise Medical Bills. A copy of the notice is provided to students with their EOC on their Wellfleet School Web Page.

A copy of the "Notice" is included below and is also provided to student with their Explanation of Coverage on their Wellfleet School Web Page.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if

you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan year out-of- pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in- network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the Department of Health and Human Services to reach the entity responsible for enforcing the federal balance or surprise billing protection laws at 1-800- 985-3059.

Visit https://www.cms.gov/nosurprises for more information about your rights under federal law

Dental Benefits and Coverage:

Wellfleet Insurance Company does not offer a Dental Provider network on any of our Student Health Insurance plans. Members can use any dentist and the benefit is reimbursed as outlined in the WV Certificate of Coverage that is available to members on their Wellfleet School webpage. A copy of the dental benefit and reimbursement section from the Certificate of Coverage is provided below.

Excerpt from the Wellfleet WV Certificate of Coverage:

Dental and Vision Benefit Payments
For dental and vision benefits, You may choose any dental or vision provider.
For dental, different benefits may be payable based on the type of service, as shown in the Schedule ofBenefits.

Note: The reimbursement percentage noted in the below chart may vary by each Wellfleet West Virginia Student Health Insurance Plan (SHIP). Members should confirm the benefit for their specific plan in the Certificate of coverage for their school which is located on the member's Wellfleet school webpage. Members can also call the Wellfleet member Service number on the back of their member ID card to confirm benefit and coverage.

Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19)	See the Pediatric Dental Care Benefit description in the Certificate for further information.
Preventive Dental Care Limited to 2 dental exams every 12 months	100% of Usual and Customary Charge
The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:	
Emergency Dental Routine	80% of Usual and Customary Charge
Dental Care Endodontic	80% of Usual and Customary Charge
Services Prosthodontic	80% of Usual and Customary Charge
ServicesPeriodontic	50% of Usual and Customary Charge
Services	80% of Usual and Customary Charge
Medically Necessary Orthodontic Care	50% of Usual and Customary Charge
Claim forms must be submitted to usas soon as reasonably possible. Referto Proof of Loss provision contained in the General Provisions.	Deductible Waived

Exhibit A – Provider Types by County – Cigna OAP

County	Provider/Facility Type Available
Barbour	Hospital, Primary Care Physicians (PCPs), OB/GYNs and/or Nurse Midwives, Outpatient SUD Provider, Psychologist, Psychiatrist, Physical Therapy, Podiatry, Radiology Services
Berkeley	Hospital, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologist, Dialysis, Endocrinology, Gastroenterologists, General Surgery, Hematology, Laboratory, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychiatrist, Psychologist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Boone	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Chiropractic, Dermatologist, Dialysis, Gastroenterologists, General Surgery, Licensed Independent Clinical Social Worker, Home Health Services, Neurologists, Pathology, Physical Therapy, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Orthopedic, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Pathology, Psychologist, Psychiatrist, Pulmonologists, Radiology Services
Braxton	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Chiropractic, Dialysis, General Surgery, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Orthopedic Surgeons, Outpatient SUD Provider, Pathology, Physical Therapy, Podiatry, Psychologist, Psychiatrist, Radiology Services
Brooke	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Chiropractic, Endocrinology, Hematology, Home Health Services, Laboratory, Licensed Independent Clinical Social Worker, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Oncologists, Outpatient SUD Provider, Otolaryngologist/Otorhinolaryngologic, Physical Therapy, Podiatry, Psychologist, Psychiatrist, Radiology Services, Thoracic Surgery
Cabell	Hospital, Neo-Natal Intensive Care Unit, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologist, Dialysis, Durable Medical Equipment (DME), Endocrinology, Gastroenterologists, General Surgery, Hematology, Laboratory, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Oncologists, Occupational Outpatient SUD Provider, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Pathology, Physical Therapy, Plastic surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology

Calhoun	Hospital, Emergency, Primary Care Physicians (PCPs), Nephrology, Orthopedic Surgeons, Radiology Services
Clay	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), General Surgery, OB/GYNs and/or Nurse Midwives, Psychologist
Doddridge	Primary Care Physicians (PCPs), Licensed Independent Clinical Social Worker,
Fayette	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dialysis, Endocrinology, Gastroenterologists, General Surgery, Licensed Independent Clinical Social Worker, Neurologists, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Physical Therapy, Plastic Surgery, Podiatry, Psychiatrist, Radiology Services
Gilmer	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Licensed Independent Clinical Social Worker, Nephrology, Physical Therapy
Grant	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Cardiologists, General Surgery, Home Health Services, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Urology
GreenBrier	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Chiropractic, Dialysis, Endocrinology, Gastroenterologists, General Surgery, Hematology, Nephrology, Neurosurgery, Home Health Services, Laboratory, Licensed Independent Clinical Social Worker ,OB/GYNs and/or Nurse Midwives, Occupational Therapy, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Radiology Services, Urology
Hampshire	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Dermatologist Gastroenterologists, General Surgery, OB/GYNs and/or Nurse Midwives, Orthopedic Surgeons, Physical Therapy, Podiatry, Psychologist, Pulmonologists, Radiology Services,
Hancock	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dermatologists, Dialysis, Durable Medical Equipment (DME), Endocrinology, Gastroenterologists, General Surgery, Licensed Independent Clinical Social Worker, Hematology, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Obstetric Services, Occupational Therapy, Oncologists, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Hardy	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Cardiologists, Nephrology, OB/GYNs and/or Nurse Midwives, Orthopedic Surgeons, Psychologist
Harrison	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dermatologists, Dialysis, Durable Medical Equipment (DME), Endocrinology, Gastroenterologists, General Surgery, Hematology, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Occupational Therapist, Oncologists, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Pathology, Physical

	Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Jackson	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dialysis, General Surgery, Home Health Services, Nephrology, Neurosurgery, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Radiology Services
Jefferson	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dialysis, Endocrinology, General Surgery, Hematology, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic, Orthopedic Surgeons, Physical Therapy, Psychologist, Psychiatrist, Plastic Surgery, Podiatry, Pulmonologists, Radiology Services
Kanawha	Hospital, Neo-natal intensive care unit, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologists, Dialysis, Durable Medical Equipment (DME), Endocrinology, Gastroenterologists, General Surgery, Hematology, Laboratory, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Oncologists, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Lewis	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Dialysis, Durable Medical Equipment (DME), Gastroenterologists, General Surgery, Hematology, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Outpatient SUD Provider, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Urology
Lincoln	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), OB/GYNs and/or Nurse Midwives, Psychologist, Psychiatrist, Pulmonologists,
Logan	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dermatologists, Durable Medical Equipment (DME), Gastroenterologists, General Surgery, Hematology, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Orthopedic Surgeons, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Pulmonologists, Radiology Services, Urology
Marion	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Audiologists, Cardiologists, Chiropractic, Dermatologists, Dialysis, Durable Medical Equipment (DME), Gastroenterologists, General Surgery, Hematology, Nephrology, Home Health Services, Laboratory, Licensed Independent Clinical Social Worker, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Oncologists, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Pathology, Physical Therapy, Podiatry, Plastic Surgery, Podiatry, Psychologist,

	Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Marshall	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Gastroenterologists, General Surgery, Hematology, Home Health Services, Licensed Independent Clinical Social Worker, Neurologists, Nephrology, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Orthopedic Surgeons, Outpatient SUD Provider, Pathology, Podiatry, Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Mason	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Cardiologists, Dialysis, Durable Medical Equipment (DME), General Surgery, Hematology, Home Health Services, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Otolaryngologist/Otorhinolaryngologic, Oncologists, Orthopedic Surgeons, Pathology, Physical Therapy, Podiatry, Psychologist, Pulmonologists, Radiology Services
McDowell	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Audiologists, Anesthesiology, Durable Medical Equipment (DME), Home Health Services, Physical Therapy, Nephrology, OB/GYNs and/or Nurse Midwives, Outpatient SUD Provider, Radiology Services
Mercer	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Dermatologist, Dialysis, Durable Medical Equipment (DME), General Surgery, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Pathology, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Urology
Mineral	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Chiropractic, Dialysis, General Surgery, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Pathology, Physical Therapy, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Urology
Mingo	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Audiologists, Cardiologists, Ophthalmologists, Outpatient SUD Provider, Pathology, Physical Therapy, Podiatry, Psychologist, Pulmonologists
Monongalia	Hospital, Neo-natal intensive care unit, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dermatologists, Dialysis, Endocrinology, Gastroenterologists, General Surgery, Hematology, Home Health Services, Laboratory, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgeon, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Pathology, Psychologist, Psychiatrist Pulmonologists, Physical Therapy, Podiatry, Radiology Services, Thoracic Surgery, Urology
Monroe	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), ,Chiropractic, Licensed Independent Clinical Social Worker, Ophthalmologists, , Psychologist

Morgan	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Gastroenterologists, General Surgery, Licensed Independent Clinical Social Worker, OB/GYNs and/or Nurse Midwives, Orthopedic Surgeons, Outpatient SUD Provider, Physical Therapy, Pulmonologists, Podiatry, Radiology Services
Nicholas	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dialysis, Durable Medical Equipment (DME), Endocrinology, General Surgery, Neurologists, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Pathology, Physical Therapy, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Urology
Ohio	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologists, Dialysis, Durable Medical Equipment (DME), Endocrinology, Gastroenterologists, General Surgery, Hematology, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Obstetric Services, Occupational Therapy, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Pulmonologists, Psychologist, Psychiatrist, Radiology Services, Thoracic Surgery, Urology
Pendleton	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Occupational Therapy
Pleasants	Primary Care Physicians (PCPs), Licensed Independent Clinical Social Worker, Physical Therapy, Podiatry, Psychologist, Radiology Services
Pocahontas	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Cardiologists, General Surgery, Home Health Services, OB/GYNs and/or Nurse Midwives, Outpatient SUD Provider, Physical Therapy, Podiatry, Psychiatrist, Radiology Services
Preston	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, Dialysis, General Surgery, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Physical Therapy, Psychiatrist, Pulmonologists, Radiology Services, Urology
Putman	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologists, Durable Medical Equipment (DME), Endocrinology, Gastroenterologists, General Surgery, Hematology, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgery, OB/GYNs and/or Nurse Midwives, Occupational Therapy, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Raleigh	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologists, Durable Medical Equipment (DME), Endocrinology,

	Gastroenterologists, General Surgery, Hematology, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Urology
Randolph	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dermatologists, Dialysis, Gastroenterologists, General Surgery, Hematology, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Pathology, Physical Therapy, Podiatry, Psychologist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Ritchie	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Chiropractic, Home Health Services, Physical Therapy
Roane	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Cardiologists, General Surgery, Home Health Services, Neurosurgery, Orthopedic Surgeons, Pathology, Physical Therapy, Podiatry, Pulmonologists, Radiology Services
Summers	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), General Surgery, Hematology, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Orthopedic Surgeons, Pathology, Physical Therapy, Podiatry, Psychologist
Taylor	Hospital, Emergency, Primary Care Physicians (PCPs), Cardiologists, Dialysis, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Physical Therapy, Psychologist, Psychiatrist
Tucker	Hospital Primary Care Physicians (PCPs), Cardiologists, General Surgery, OB/GYNs and/or Nurse Midwives, Physical Therapy, Podiatry, Psychologist, Psychiatrist
Tyler	Hospital, Emergency, Primary Care Physicians (PCPs), Orthopedic Surgeons, Podiatry, Pulmonologists, Radiology Services
Upshur	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Anesthesiology, Audiologists, Cardiologists, Chiropractic, Dialysis, Gastroenterologists, General Surgery, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Pathology, Physical Therapy, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Urology
Wayne	Hospital Access, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Audiologists, Cardiologists, Licensed Independent Clinical Social Worker, OB/GYNs and/or Nurse Midwives, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Physical Therapy, Psychologist, Psychiatrist
Webster	Hospital Access, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Cardiologists, Nephrology, OB/GYNs and/or Nurse Midwives, Physical Therapy

Wetzel	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dermatologists, Dialysis, Gastroenterologists, General Surgery, Hematology, Home Health Services, Nephrology, Neurologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Obstetric Services, Pathology, Podiatry, Pulmonologists, Thoracic Surgery, Urology
Wirt	Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Cardiologists, Home Health Services
Wood	Hospital Access, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Allergists, Anesthesiology, Cardiologists, Chiropractic, Dermatologists, Dialysis, Endocrinology, Gastroenterologists, General Surgery, Hematology, Home Health Services, Licensed Independent Clinical Social Worker, Nephrology, Neurologists, Neurosurgeon, OB/GYNs and/or Nurse Midwives, Oncologists, Ophthalmologists, Orthopedic Surgeons, Otolaryngologist/Otorhinolaryngologic, Obstetric Services, Outpatient SUD Provider, Pathology, Physical Therapy, Plastic Surgery, Podiatry, Psychologist, Psychiatrist, Pulmonologists, Radiology Services, Thoracic Surgery, Urology
Wyoming	Hospital, Emergency, Pediatric or Age Appropriate Primary Care Physicians (PCPs), Primary Care Physicians (PCPs), Chiropractic, Dialysis, Home Health Services, Laboratory, Physical Therapy, Podiatry