Wellfleet Insurance Company
Colorado Network Access Plan – 2022
With the Cigna PPO Network

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

WIC files our CO SHIP Rate and Form filings in SERFF. Our Form filing includes a copy of the CO Policy and Certificate of Coverage that is provided to students at our CO SHIP schools. Members can access their Policy and Certificate of Coverage on the Wellfleet Website at this link: https://wellfleetstudent.com/.

Wellfleet Quality Management Program

Wellfleet maintains 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, strive to continuously improve the level-of-care and service rendered to students, members and customers.

Wellfleet's Quality Management (QM) Program addresses medical care, behavioral health (BH) care, pharmacy services and the degree to which they are coordinated. The program 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 Wellfleet 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.

The Wellfleet QM program includes initiatives to improve the quality of services we provide to our members. The QM program is updated on an annual basis and new initiatives are included each year. The Quality Committees discuss and decide which initiatives are included in each year's QM program.

The QM program is comprised of various documents including those noted below.
1.Quality Management Program Description
2. Quality Management Program Evaluation

Members and Providers can access a copy of Wellfleet's Quality Management Program by contacting our Member Service Team at the phone number on the back of the members' ID card or by selecting the link on the Wellfleet website as noted below.

The below notice is posted on the Wellfleet Website to guide members and providers how to request a copy of the WIC QM Program documents.

Notice Posted on WF Website (on the "Student" dropdown tab under "Form and Resources"):

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**

Cigna Quality Assurance Standards

Quality Program Scope
Cigna's Quality Program provides direction to management for the coordination of both quality improvement and quality management activities across all departments, matrix partners, health services affiliates and delegates. The Program outlines quality-monitoring standards and provides guidance in initiating process improvement initiatives when opportunities are identified. Quality Studies are designed and documented to objectively and systematically monitor, evaluate and improve the quality and appropriateness of care and service.

Quality Program Measurement Activities
- Reviewing performance against key indicators as specifically identified in the quality work plan.
- Promotion of quality clinical care and service, including both inpatient and outpatient services, provided by hospitals and health care professionals.
- Evaluating satisfaction information, including survey data and complaint and appeal analysis.

Annual Evaluation
An annual evaluation is conducted to assess the overall effectiveness of the various organizations' quality improvement processes. The evaluation reviews all aspects of the Quality & Medical Management Programs with emphasis on determining whether the Program has demonstrated improvements in the quality of health care professional care and services that are provided through the organizations. The annual evaluation includes:
- The impact the quality improvement process had on improving health care and service to individuals.
- An assessment of whether the year's goals and objectives were met.
- A summary of and whether improvements were realized.
- Potential and actual barriers to achieving goals.
- A review of whether human and technological resources were adequate.
- An analysis of Cigna membership demographics, cultural and linguistic needs, and epidemiology is performed as needed or as required by state regulators.
- An analysis of the Cigna member population characteristics to evaluate and ensure membership needs are being met through the complex and specialty case management processes and resources.
- Recommendations for program revisions and modifications for the coming year.

The annual evaluation is reviewed and approved by the appropriate quality committee and the Quality Management Governing Body. The results of the annual program evaluation are used to develop and prioritize the annual work plan for the upcoming year.

Access Plan Elements

Provider and Facility Availability

Cigna's adheres to a provider and facility availability policy which helps ensure that Cigna maintains an adequate network of health care professionals and facilities and monitors how effectively the network meets the needs and preferences of its clients and meets the Colorado requirements for having and maintaining an adequate network. The provider availability policy also helps ensure that the provider network meets the availability needs of clients by annually assessing three (3) aspects of availability. Assessments are performed against Cigna's book of business. Wellfleet gages provider and facility availability by reviewing member census report and the WIC w Cigna PPO CO provider to members report and the Medical Enrollment Template.

- Geographic distribution - participating health care professionals are within reasonable proximity to clients.

- Number of health care professional(s) - an adequate number of participating health care professional(s) are available, and
- Cultural, ethnic, racial and linguistic needs and preferences of participating health care professional(s) meet the cultural, ethnic, racial and linguistic needs and preferences of clients.

The Cigna National Network Development Team conducts an annual audit of provider availability by state/market. The analysis is conducted utilizing available software such as GEO Access, Quest Analytics or Map Xtreme, using established standards to ensure a sufficient number of participating health care professionals and facilities are available. The analysis is conducted to ensure that Cigna is complying with the CO network adequacy requirements. (Note, assessments are performed against Cigna's book of business. The measurements used for Colorado are noted below). Wellfleet provides Cigna with a list of our Colorado School SHIP members and Cigna uses that enrollment list to complete the CO Enrollment template to assess provider to member ratios.

As required by Colorado regulations, the following availability standards are followed:

Access to Service/Waiting Time Standards

Service Type	Time Frame	Time Frame Goal
Emergency Care – Medical, Behavioral, Substance Abuse	24 hours a day, 7 daysa week	Met 100% of the time
Urgent Care – Medical, Behavioral, Mental Health and Substance Abuse	Within 24 hours	Met 100% of the time
Primary Care – Routine, non-urgent symptoms	Within 7 calendar days	Met > 90% of the time
Behavioral Health, Mental Health and Substance Abuse Care-Routine, non-urgent, non-emergency	Within 7 calendar days	Met> 90% of the time
Prenatal Care	Within 7 calendar days	Met> 90% of the time
Primary Care Access to after-hours care	Office number answered 24 hrs./7 days a week by answering service or instructions on how to reach a physician	Met> 90% of the time
Preventive visit/well visits	Within 30 calendar days	Met> 90% of the time
Specialty Care – non urgent	Within 60 calendar days	Met > 90% of the time

In remote or rural areas, occasionally these geographic availability guidelines are not able to be met due to lack of, or absence of, qualified providers and/or hospital facilities. Cigna may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval.

Cigna/Evernorth Behavioral Health also has facility, clinic and individual practitioner contracting policies in place to help ensure adequate coverage for behavioral health needs.

In the event that Cigna determines that the network does not meet the adequacy requirements, Cigna's medical recruitment team (MRT) is engaged. The MRT makes phone call and/or sends e-mails to viable providers. A minimum of 3 attempts are made to the Provider. Any interested Provider is sent materials to allow the Provider to join the network.

Medical Services Accessibility

Accessibility to medical care is formally assessed against standards at least annually.

Accessibility standards for customers are as follows:

- Emergency: Immediately. 24 hours a day, 7 days a week
- Urgent: Within 24 hours* (Urgent medical needs are those that are not emergencies but require prompt medical attention, such as symptomatic illness and infections).
- Symptomatic Regular and Routine Care: 7-14 days, or within the timeframe specified by treating physician
- Preventive Screenings and Physical: Within 30 days
- Obstetric Prenatal Care**:**
    - High-risk or urgent: Immediately
    - Non-high risk and non-urgent: 1st trimester, within 14 days; 2nd trimester, within 7 days, 3rd trimester, within 3 days
- Routine and Symptomatic Diagnostic Testing**:** Within the timeframe specified by treating health care professional. Appointments for symptomatic testing are usually provided in shorter timeframesthan routine testing.
- After hours care: Health Care Professional provides 24-hour coverage

Having and Maintaining Adequate Networks - Telemedicine

Telemedicine is a viable alternate care delivery method which enhances the effectiveness and efficiency of the provider/patient relationship by making access to care more convenient while appropriately compensating providers for their services. Cigna directly contracts with providers who offer telehealth services. Geographic accessibility in some circumstances may be available through the use of telehealth. Cigna contracted providers who offer virtual services are noted in the Cigna Provider Directory.

Primary Care Provider Referrals

Under Wellfleet SHIP plans, a referral from a Primary Care provider is typically not required to see a Specialist. However, if the SHIP plan school has a Student Health Center (SCH), then the school may require the student to seek services from the SHC prior to receiving services from a Specialist in the PPO network on the plan. In this case, if an Insured Student does not obtain a Referral from the Student Health Center the services may not be covered. This provision is outlined in the Wellfleet CO Certificate of Insurance that is provided to CO SHIP school members as shown below.

The below language is included in the Wellfleet 2020/2023 CO SHIP Certificate of Coverage:

SECTION III – STUDENT HEALTH CENTER REFERRAL

Where available, the student should first use the resources of the Student Health Center (SHC) where Treatment will be administered, or a referral issued that verifies that the services were not available at the SHC. You are then free to seek services outside the SHC. Expenses incurred for medical Treatment rendered outside of the SHC for which no prior approval or referral is obtained will be subject to the Referral Penalty shown on the Schedule of Benefits. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary ONLY under the following conditions:

1. For an Emergency Medical Condition. The student must return to the SHC for necessary follow-up care;
2. When the SHC is closed;
3. For medical care received when the student is more than 20 miles from campus;
4. For medical care obtained when a student is no longer able to use the SHC due to a change in student status;
5. For maternity care;
6. When service is rendered at another facility during break or vacation period.

Additionally, no authorization or referral requirement will apply to obstetrical or gynecological care provided by In Network Providers.

The applicable Deductible(s); Coinsurance and Copayment(s) shall apply to all of the exceptions to the referral requirement shown above.

Prior Authorization/Pre-Certification for Inpatient and Outpatient Services

Prior authorization/Pre-Certification is required for non-emergency inpatient admissions, and certain outpatient services as outlined in the member's certificate of coverage. Failure to obtain prior authorization prior to an elective admission to a hospital or certain other facility may result in a penalty or lack of coverage for the services provided. Prior Authorization can be obtained by the customer or provider by calling the number on the back of the customer's ID card. Emergency admissions will be reviewed post admission. Inpatient prior authorization reviews are conducted for both the necessity for the admission and the need for continued stay in the hospital.

Complaints, Appeals and Grievances

Wellfleet's CO SHIP Certificate of Coverage that is provided to CO SHIP students includes the below Appeals and Grievance language and process. Wellfleet also maintains a Complaints, Appeals and Grievance Policy that includes this process.

Definitions

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 WIC makes an Adverse Benefit Determination, then the member may appeal according to the following steps.

Internal Appeals

If the member does not agree with WIC's decision and wishes to appeal, they must file a written appeal with Us at the address below within 180 days after receipt of the Adverse Benefit Determination notification (or oral notice if an Urgent Care request) . If the claim involves Urgent Care, the member's appeal may be made orally.

The member should submit all necessary information with their appeal. The member should gather any additional information that is identified in the adverse benefit determination notice as necessary to perfect their claim and any other information that they believe will support their claim.

Appeals should be sent to:
Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
(877) 657-5030

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 following receipt of the Adverse Benefit Determination	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days following receipt of the Adverse Benefit Determination	72 hours of receipt of appeal
Concurrent: To end or reduce Treatment prematurely	180 days after receipt of Adverse Benefit Determination Pending the outcome of the appeal, benefits for an ongoing course of Treatment will not be reduced or terminated.	15 days of receipt of appeal
Concurrent: To deny Your request to extend Treatment	180 days following receipt of the Adverse Benefit Determination 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 following receipt of the Adverse Benefit Determination	72 hours of receipt of appeal
Post-Service Claim	180 days following receipt of the Adverse Benefit Determination	60 days of receipt of appeal

External Reviews

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

They may also seek an external review by an IRO for a denial of an Urgent Care request based on medical judgement provided that (1) They 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 their life or health or would seriously jeopardize their ability to regain maximum function.

They 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, the member may file a request for an external review with WIC or Colorado's Commissioner of Insurance.

The member must file their written request for an external review with WIC within 4 months of the date the member received the applicable denial.

Within 5 business days of receiving the member's request for an external review, WIC will complete a preliminary review of the request to determine whether the member was covered under the Policy at the time the expense was incurred and whether the member has exhausted the Internal Appeal process where required.

In most cases, the member should complete WIC's Internal Appeals process before they:

• File a complaint or appeal with the Colorado's Department of Insurance;
• File a request for an External Review;

• Pursue arbitration, litigation or other type of administrative proceedings.

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

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

Within 1 business day of making a determination, the member will be notified if the external review request is denied and they 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 the

member's request is denied due to lack of information or materials, they must perfect their 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 the member request for external review was denied.

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

External Review of Denial of Experimental or Investigative Treatment

If, due to the members medical condition, the time frame for completion of the standard external review process would seriously jeopardize the member's life or health or the member's ability to regain maximum function, the member may request an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, WIC will assign the request to an IRO and the IRO will complete the review as expeditiously as the member's medical condition requires, but in no event more than 72 hours after receiving the request. If the notice is provided to the member orally, a written or electronic notification will be sent to the member 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 level of appeal will not be involved in the appeal).
- The claims reviewer will review relevant information that the member submits even if it is new information. In addition, the member has the right to request documents or other records relevant to their claim.
- If a claim involves medical judgement, then the claims reviewer will consult with an independent health care professional that has expertise in the specific area involving medical judgment.
- The member may review the claim file and present evidence and testimony at each state of the appeals process.
- The member may request, free of charge, any new or additional evidence considered, relied upon, or generated by WIC in connection with their claim.
- If a decision is made based on new or additional rationale, the member will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If the member wishes to submit relevant documentation to be considered in reviewing their claim for appeal, it must be submitted with their claim and/or appeal.
- The member should exhaust these appeals procedures before filing a complaint or appeal with the Colorado Department of Insurance.

- The member should raise all issues that they wish to appeal during the Internal Appeal process and during the External Review.

Contact Information

If the member has any questions or concerns, they can contact WIC at:
WIC Insurance Company
Attention: Appeals Unit
WIC Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369
877-657-5030

The member may contact the Colorado Department of Insurance for assistance at any time.
Address:

Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, CO 80202
(303) 894-7944
(800) 930-3745

Ongoing Monitoring

Health Care Professional Availability and Accessibility monitoring is conducted on an ongoing basis and an analysis is performed annually to ensure that established standards for reasonable geographical location, number of practitioners, hours of operation, appointment availability, provision for emergency care and after hours services are measured. (Note, assessments are performed against Cigna's book of business. Wellfleet gages provider and facility availability by reviewing member census report and the WIC w Cigna PPO CO provider to members report and the Medical Enrollment Template.

Monitoring activities may include evaluation of satisfaction surveys, on-site visits, evaluation of complaint and appeal reports, geo-access surveys, evaluation of health care professionals to member ratios, and monitoring of closed primary care physician panels. An assessment of the health care professional network is also performed to ensure that the network meets the cultural, ethnic, and linguistic needs and preferences of individuals. Specific deficiencies are addressed with a corrective action plan and follow up activities are conducted to reassess compliance. Data are presented to the Service Advisory Committee for evaluation and recommendations. (Note, assessments are performed against Cigna's book of business only. Wellfleet gages provider and facility availability and accessibility by reviewing member census report and the WIC w Cigna PPO CO provider to members report and the Medical Enrollment Template.

Needs of Special Populations and Persons with Physical Limitations

Wellfleet's Certificate of Coverage that is provided to CO SHIP school members includes a section titled, "NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS". This language states, "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."

Wellfleet has adopted internal policies and procedures to meet the needs of users with special accessibility needs. TTY 711 relay service is displayed on the company website, in benefit summaries and brochures. Claims and Customer Service areas have policies and procedures and have been trained on them. The Certificate of Coverage/EOC notifies members of the services and company commitment to accessibility.

Wellfleet 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 members need these services, they contact the Wellfleet Customer Service and/or Legal team.

Wellfleet Web Content Accessibility Guidelines: If you are a person with a disability who needs assistance using our website, our Customer Service Representatives can assist you. Please call them at the number on your member ID Card or (800) 633-7867 from 8:30 AM – 7 PM EST
Monday -Thursday and Friday 8:30 AM – 5 PM

Wellfleet strives to continuously improve our website experience to meet or exceed universal design best practices and web accessibility standards. We are committed to making our information accessible to everyone, including people with disabilities. To meet this commitment, we have adopted Web Content Accessibility Guidelines (WCAG) 2.0 AA as our corporate standard.

In addition to providing our members with special needs and physical limitations, access to a language line, TTY services, documents transcribed in different languages and sign language interpreters, the provider networks Wellfleet contracts with have providers who offer telehealth visits for members who cannot physically go into an office. Providers also have handicapped accessible offices to assist members with physical limitations.

Also, all Wellfleet employees are required to complete annual Diversity, Equity and Inclusion Training which equips our employees with information about providing service to members with diverse cultural and special populations.

Members who are on Case Manaement will also have access to a Case Manager who can assist with their physical limitations including special equipment, etc. related to their physical need.

Out-of-Network Provider Paid at In-Network Level

Wellfleet has an “Out-of-Network Provider Paid at In-Network Level” guideline for our Customer Service Representatives to follow to assist members who contact the Wellfleet Customer Service team using the number on their member I.D. card. This guideline applies when there are no in-network participating providers available to treat a member as outlined in the guide. This provision is also outlined in the member’s Explanation of Coverage (EOC).

Continuity of Care

The below explanation of Continuity of Care is included in the Wellfleet CO Certificate of Coverage that is provided to our members,

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 90 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 pregnancy. The transitional period must extend through the provision of postpartum care directly related to the pregnancy.

A copy of Wellfleet's Continuity of Care Form for members to complete and submit to Wellfleet's Clinical Team for Review and consideration is located on our website. If the requested service is approved for "Continuity of Care", the Wellfleet Clinical Reviewer will review all documentation provided by the member and/or their provider prior to a decision being made. The Clinical Reviewer will also communicate by letter to the member and provider the instructions for discharge planning. In addition, Wellfleet has a "Continuity of Care" guideline for our Customer Service Representatives and Clinical Team to follow to assist members who contact the Wellfleet Customer Service team using the number on their member I.D. card. This provision is also outlined in the member's Explanation of Coverage (EOC).

In the event the provider you are currently seeing leaves the PPO network on your plan, Wellfleet will send you a letter notifying you the provider left the network and will provide instructions in the letter of how to locate an alternative provider. In the event of the carrier's insolvency or other cessation of operations, Wellfleet will send you a letter notifying you of the incident and will provide instructions of continuation of care.

Wellfleet's delegated provider networks, include language in their provider contracts that holds the member harmless in the event any of the above noted situations arise, as long as the member is covered under the plan.

How to Locate Information About the Wellfleet Student Health Insurance Plan

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/.

Member Satisfaction Assessment

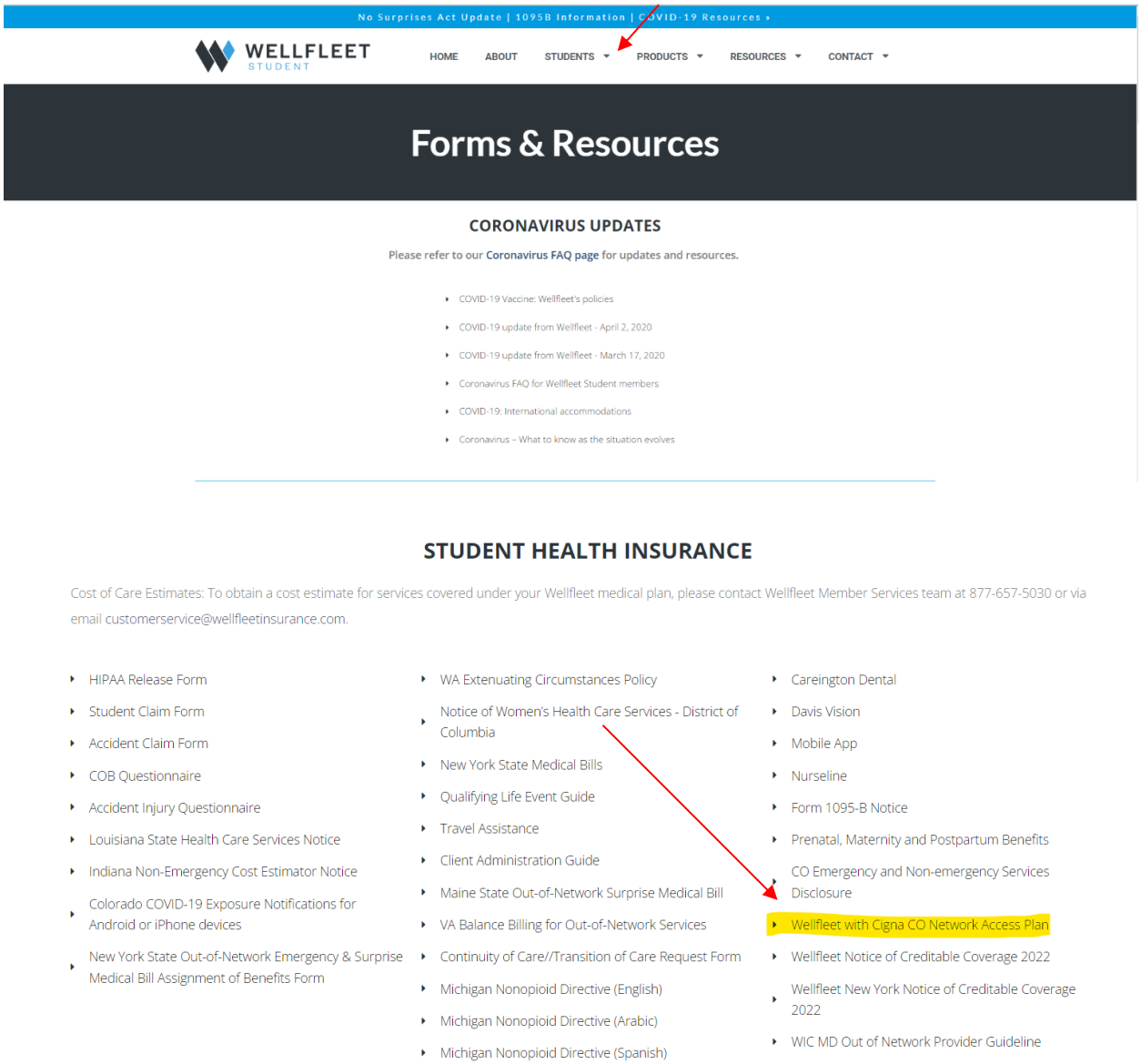
Satisfaction is assessed through evaluation of Wellfleet's annual member satisfaction survey data and complaint information. Wellfleet also sends customer service satisfaction surveys to members who contact our customer service team. Satisfaction surveysare designed to assess satisfaction with the organization's services. Survey data are used for continuous quality improvement in several key areas: 1) to establish benchmarks and monitor performance, 2) to assess overall levels of satisfaction as an indication of whether the organization is meeting individual expectations, 3) to assess programs and health care professional satisfaction levels and 4) to assess the quality, accuracy and ease of accessing benefit and plan information provided by the organization.

Access Plan

A copy of Wellfleet's CO Network Access Plan is available to members on the Wellfleet website on this URL https://wellfleetstudent.com/forms/. Screen shots of how to locate the form once the link is clicked is provided below. Members may also contact the Wellfleet Customer Service team at the phone number on their I.D. card to obtain a copy of the access plan.

After clicking the above link, click the drop down arrow near "STUDENTS", as shown below by the red arrow and click on "FORMS".

When you click on "FORMS" link from the drop down arrow, the "Forms & Resources" screen will open as shown below. On the "FORMS & Resources" page, scroll down to the link to access the "Wellfleet with Cigna Co Network Access Plan" as shown by the red arrow.


No Surprises Act Update | 1095B Information | COVID-19 Resources »
WELLFLEET STUDENT
HOME
ABOUT
STUDENTS
PRODUCTS
RESOURCES
CONTACT
Forms & Resources
CORONAVIRUS UPDATES
Please refer to our Coronavirus FAQ page for updates and resources.
COVID-19 Vaccine: Wellfleet's policies
COVID-19 update from Wellfleet - April 2, 2020
COVID-19 update from Wellfleet - March 17, 2020
Coronavirus FAQ for Wellfleet Student members
COVID-19: International accommodations
Coronavirus – What to know as the situation evolves
STUDENT HEALTH INSURANCE
Cost of Care Estimates: To obtain a cost estimate for services covered under your Wellfleet medical plan, please contact Wellfleet Member Services team at 877-657-5030 or via email customerservice@wellfleetinsurance.com.
HIPAA Release Form
Student Claim Form
Accident Claim Form
COB Questionnaire
Accident Injury Questionnaire
Louisiana State Health Care Services Notice
Indiana Non-Emergency Cost Estimator Notice
Colorado COVID-19 Exposure Notifications for Android or iPhone devices
New York State Out-of-Network Emergency & Surprise Medical Bill Assignment of Benefits Form
WA Extenuating Circumstances Policy
Notice of Women's Health Care Services - District of Columbia
New York State Medical Bills
Qualifying Life Event Guide
Travel Assistance
Client Administration Guide
Maine State Out-of-Network Surprise Medical Bill
VA Balance Billing for Out-of-Network Services
Continuity of Care//Transition of Care Request Form
Michigan Nonopioid Directive (English)
Michigan Nonopioid Directive (Arabic)
Michigan Nonopioid Directive (Spanish)
Careington Dental
Davis Vision
Mobile App
Nurseline
Form 1095-B Notice
Prenatal, Maternity and Postpartum Benefits
CO Emergency and Non-emergency Services Disclosure
Wellfleet with Cigna CO Network Access Plan
Wellfleet Notice of Creditable Coverage 2022
Wellfleet New York Notice of Creditable Coverage 2022
WIC MD Out of Network Provider Guideline