Wellfleet Insurance Company
Arkansas Network Access Plan – 2024
With the Cigna Network

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

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

The WIC SHIP Plans, Certificate of Coverage and Policies and Procedures include items required by AR Insurance Department Network Adequacy Requirements For Health Benefit Plans, Rule 106, Section 5, (I), items (1) through (12) which include but are not limited to the following items.

AR Insurance Department- Rule §106-Section 5-(I)(1)

The Health Carrier's Network.

The WIC AR SHIP provides access to a Preferred Provider Network and for AR SHIP the Cigna network is used. The plan 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 Plan's Schedule of Benefits in the Certificate of Coverage.

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 for Covered Medical Expenses shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Wellfleet may be the member's responsibility.

Provider networks are open to any provider that is willing to join the network, meets the credentialing criteria and agrees to the contract terms and fees. Providers applying for network participation are required to sign an agreement for participation and complete the credentialing process prior to becoming a participating provider, and are re-credentialed every 36 months thereafter, to ensure they continue to meet the network qualifications for participation. The criterion 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.

Arkansas Insurance Department- Rule §106-Section 5-(I)(2)

The Health Carrier's procedures for making referrals within and outside its network and for notifying enrollees and potential enrollees regarding availability of network and out-of-network providers.

Cigna contracted providers are obligated to refer patients/members to other in-network providers. This requirement is outlined in the provider's network contract.

Under Wellfleet SHIP plans, a referral from a Primary Care provider to a Specialty provider is typically not required. However, if the SHIP plan school has a Student Health Center (SHC), then the school may require the student to seek services from the SHC prior to receiving services from a Specialist in the Cigna network. In this case, if an Insured Student does not obtain a Referral from the SHC, the services may not be covered. If this provision applies to the SHIP plan, it is reflected in the WIC AR Summary of Benefits and Coverage, in the Certificate of Coverage and on the Member's Identification Card that is provided to AR SHIP school members. Members can locate in network providers by using the network link on their ID card or on their Wellfleet school landing page, or by calling the Wellfleet Customer Service phone number on their ID card.

Arkansas Insurance Department- Rule §106-Section 5-(I)(3)

The process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in its health benefit plans.

Wellfleet works with Cigna to monitor the network including but not limited to, requesting GeoAccess reports to monitor provider to member ratios.

Wellfleet provides our network partner with a list of AR SHIP members and our network partner populates a Network Access Report which identifies the member to in-network provider ratio report.

In addition, Wellfleet has a formal Delegation Oversight Committee that monitors our vendor partners. A delegation oversight tool is used to monitor vendor services and these oversight tools are presented to Wellfleet's Quality Program Management Committee, Delegation Oversight Committees and Executive Quality Program Management Committee at reoccurring Quality Program Meetings.

Arkansas Insurance Department- Rule §106-5-(I)(4)

The Health Carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities.

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

In addition, the below Notice of Non-Discrimination and Accessibility Requirements is also included in the Wellfleet 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 the 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:

Civil Rights Coordinator,
PO Box 15369
Springfield, MA 01115-5369
(413) 733-4540
civilcoordinator@wellfleetinsurance.com

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance our 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
800-868-1019; 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.

Arkansas Insurance Department- Rule §106-5-(I)(5)

The Health Carrier's methods for assessing the health care needs of covered persons.

Members who contact the Wellfleet Customer Service Team will receive a short survey to complete after they complete their call with the Customer Service Representative. The Survey gathers feedback about the member's experience with the Custom Service Representative to confirm if the member's inquiry and questions were fully resolved to the member's satisfaction during the call.

In addition, Wellfleet will send an annual member satisfaction survey to members at our Arkansas SHIP schools to assess their satisfaction with services.

A**rkansas Insurance Department- Rule §106-5-(I)(6)(a)**

The Health Carrier's method of informing Covered persons of cost sharing.

Wellfleet's AR Certificate of Coverage includes detailed information regarding member cost sharing, such as in network and out of network benefits and out of pocket amounts.

Arkansas Insurance Department- Rule §106-5-(I)(6)(b)

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

Wellfleet's AR Certificate of Coverage includes detailed information regarding the plan's grievance and appeal procedures. A description of the process outlined in the Certificate of Coverage is shown below.

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.

If You receive Emergency Services from an Out-of-Network Provider, or You incur non-emergency Covered Medical Expenses from an Out-of-Network

Provider at an In-Network Hospital or Ambulatory Surgical Center, and You believe those services should have been paid at the In-Network level, You have the right to appeal that claim. If Your appeal of a Surprise Billing claim is denied, You have a right to seek an external review by an Independent Review Organization (IRO) as set out in the Standard External Review and Expedited External Review provisions appearing in this section.

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 PreService 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 of extension 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 a statement 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 after receipt of the Adverse Benefit Determination 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 1 with Your appeal. You should gather any additional information that 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

Wellfleet Group, LLC

P.O. 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 after receipt of Adverse Benefit Determination	30 days of receipt of appeal
Pre-Service Claim involving Urgent Care	180 days after receipt of 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 after receipt of 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 after receipt of Adverse Benefit Determination	72 hours of receipt of appeal
Post-Service Claim	180 days after receipt of Adverse Benefit Determination	60 days of receipt of appeal

***Step 3**:*

If Your 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 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 jeopardize Your ability to regain maximum function.

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

The determination of an IRO is binding on both You and Us, except to the extent that other remedies are available under applicable federal or state law. You may not file a subsequent request for an external review involving the same Adverse Benefit Determination.

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 Your state's 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 Your state's Department of Insurance to request an investigation of a claim determination or appeal;

• File a complaint or appeal with Your state's 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 have Your 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 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 You;

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 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, You must 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 seriously jeopardize 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 to an 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 level of 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 care professional 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 in connection with Your claim.

• If a decision is made based on new or additional rationale, You will be provided with the rationale and be given a reasonable 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 be submitted with Your claim and/or appeal.

• You should exhaust these appeals procedures before filing a complaint or appeal with Your state's Department of Insurance.

• You should raise all issues that You wish to appeal during Our Internal Appeal process and during the External Review.

CONTACT INFORMATION

If You have any questions or concerns, You can contact Us at:

Wellfleet Insurance Company
Attention: Appeals Unit
Wellfleet Group, LLC
P.O. Box 15369
Springfield, MA 01115-5369

Policyholders have the right to file a complaint with the Arkansas Insurance Department (AID). You may call AID to request a complaint form at (800) 852-5494 or (501) 371-2640 or write the Department at:

Arkansas Insurance Department
1 Commerce Way, Suite 102
Little Rock, AR 72202

Arkansas Insurance Department- Rule §106-5-(I)(6)(c)

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

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 included in the Wellfleet Certificate of Coverage that describes this process.

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.

Arkansas Insurance Department- Rule §106-5-(I)(6)(d)

A description of methods used to inform covered persons of the plan's procedures for providing and approving emergency and specialty care.

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

When You receive Emergency Services, or certain non-emergency Treatment by an Out-of-Network Provider at an In Network Hospital or Ambulatory Surgical Center, You are protected from Surprise Billing. In these situations, Your cost sharing responsibility will be calculated as if the total amount that would be charged for the services by an In-Network Provider or facility were equal to the Recognized Amount for the services, which is generally defined either as an amount set by state law or the lesser of the billed charges and the Qualifying Payment Amount. Refer to the Preferred Provider Organization provision in the How The Plan Works And Description Of Benefits section for additional information.

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.

If an Out-of-Network Provider is used, this Certificate will pay the Coinsurance 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, and Your cost share will be applied to Your In Network Deductible and Out-of-Pocket Maximum if:

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

2. You have an Emergency Medical Condition and receive Emergency Services from an Out-of-Network Provider or facility. The most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount (such as Deductibles, 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 the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment; or

3. You receive non-Emergency Services from an In-Network Hospital or Ambulatory Surgical Center, but certain providers there may be Out-of-Network Providers. In these cases, the most those Out-of-Network Providers may bill You is the In-Network cost sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, Assistant Surgeon, hospitalist, or intensivist services. These Out-of-Network Providers can't balance bill You and may not ask You to give up Your protections not to be balance billed.

However, if You received notice from the Out-of-Network Provider of their non-network status at least 72 hours in advance, or if You make an appointment within 72 hours of the services being delivered and notice and consent is given on the date of the service, and You gave written consent to Treatment, this Certificate will pay Covered Medical Expenses at the Out-of-Network level as shown in the Schedule of Benefits. This notice and consent exception does not apply to ancillary services, which include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a Physician or non-Physician practitioner; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and laboratory services; and items and services provided by an Out-of-Network Provider in circumstances where there is no In-Network Provider who can furnish the item or service at the relevant facility.

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.

EMERGENCY SERVICES, AMBULANCE AND NON-EMERGENCY SERVICES

1. *Emergency Services only in connection with care for an Emergency Medical Condition as defined. Benefits will be paid for the use of a Hospital emergency department or independent freestanding emergency department, a medical screening examination that is within the capability of the emergency department, including ancillary services routinely available to the emergency department, pre-stabilization services and supplies after You are moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after You are Stabilized as part of Observation Services or an inpatient or outpatient stay with respect to the visit in which the other Emergency Services are furnished. Refer to the Emergency Ambulance Service provision for transportation coverage. If You receive Emergency Services from an Out-of-Network Provider or facility, the most the Out-of-Network Provider or facility may bill You is the In-Network cost sharing amount. The Post-Stabilization services will no longer qualify as Emergency Services once the Out-of-Network Provider or facility determines that You can travel using non-medical or non-emergency transportation, the Out-of-Network Provider satisfies the consent and notice requirements, and You are in a condition to receive notice of, and to consent to, Out-of-Network Treatment.*

   Payment of this benefit will not be denied based on the final diagnosis following Stabilization or Post Stabilization services.

   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. *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.*

3. *Emergency Ambulance Service, with respect to an Emergency Medical Condition, for ground transportation to a Hospital by a licensed Ambulance. Transportation from a facility to Your home is not covered. Your plan also covers transportation to a Hospital by professional air or water Ambulance when: • Professional ground Ambulance transportation is not available; • Your condition is unstable, and requires medical supervision and rapid transport; • You are travelling from one Hospital to another; and • The first Hospital cannot provide the Emergency Services You need; and • The two (2) conditions above are met.*

4. *Non-Emergency Ambulance Service for Medically Necessary transportation by a licensed Ambulance, whether by ground or air Ambulance (as appropriate), when the Medically Necessary transportation is: • From an Out-of-Network Hospital to an In-Network Hospital; • To a Hospital that provides a higher level of care that was not available at the original Hospital; • To a more cost-effective acute care Hospital/facility; or • From an acute care Hospital/facility to a sub-acute setting.*

Transportation from a facility to Your home is not covered.

Arkansas Insurance Department- Rule §106-5-(I)(7)

Method for assessing consumer satisfaction.

Wellfleet sends a customer service survey to members who contact our customer service team. Wellfleet also sends AR SHIP members an annual member satisfaction survey.

Member satisfaction is assessed through evaluation of Wellfleet's customer service and annual member satisfaction survey data and complaint information.

Survey data is 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.

Arkansas Insurance Department- Rule §106-5-(I)(8)

Method for using assessments of enrollee complaints and satisfaction to improve carrier performance.

The submission of all complaints is acknowledged in writing. The acknowledgement is sent to the complainant within 5 business days of receipt of the complaint.

A quality-of-care complaint that involves a contracted provider is forwarded to the Wellfleet Provider Network Team for review through the Provider Team's internal quality review process. Complaints regarding quality of care are acknowledged in writing upon receipt and include an explanation that the complaint will be investigated but that the member or member's representative will not receive further notification of the investigation resolution as it is considered protected as a quality investigation.

Invalid service complaints, as determined by the applicable contract, require that a staff representative contact the member or the member's authorized representative to explain the response and to advise of any rights of further appeal. If the concern is valid according to the applicable contract, a staff representative will inform the member or the member's authorized representative of the corrective action that will be taken and initiate the appropriate steps to implement the action. Responses to service complaints are issued in writing within 30 calendar days of the completed investigation. Responses to complaints that threaten legal action or seem prudent under the circumstances should be reviewed by the carrier's representative. Any matter to be reviewed shall be submitted to the carrier at least three business days prior to the response due date.

On a regular basis, the Wellfleet Appeals Manager conducts a review of member and provider complaints. The purpose of the review is to identify any complaint trends and/or possible process improvement opportunities. The Appeals Manager shares the findings of their review with Wellfleet Executive Leadership. If any improvement opportunities are identified, they will be reviewed, vetted, and prioritized by the appropriate Department Managers. If necessary, a Project Manager may be assigned to assist in the implementation of any process improvements identified by the Departmental Manager and Wellfleet's Executive Leadership.

Arkansas Insurance Department- Rule §106-5-(I)(9)

The system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

The below explanation of Continuity of Care is included in the Wellfleet AR 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.

Wellfleet's Continuity of Care/Transition of Care Request form is available on the Wellfleet website at this link: https://wellfleetstudent.com/wp-content/uploads/2024/06/Wellfleet-Continuity-of-Care-Form-June-2024.pdf

Arkansas Insurance Department- Rule §106-5-(I)(10)

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 is included in the Wellfleet Arkansas Certificate of Coverage when Wellfleet has a SHIP plan in AR. 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.

Arkansas Insurance Department- Rule §106-5-(I)(11)

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.

In addition, Wellfleet receives a list of any providers that terminate their agreement with the network. Wellfleet sends members who received services within the prior 12 months from the provider who is terminating their contract and provides the member with information how to apply for continuity of care, if applicable and the process to locate another in network provider.

In the rare event of Wellfleet's insolvency, Wellfleet would notify our members via a letter with instructions for locating alternative health insurance.

Wellfleet SHIP members may contact Wellfleet Customer Service for questions regarding their SHIP plan at: 877-657-5030 Monday – Thursday, 8:30 am – 6:00 pm EST, and Friday from 8:30 am to 5 pm EST.