Consumer Facing Network Access Plan

Certificate of Authority Name: Peak Health Insurance Corporation
NAIC: 17441
Network Coverage Area: Statewide
Network Name: Peak Health LLC

Contents:

General

Peak Health, LLC (Peak Health) is a health insurer and health insurance services company located in Morgantown, West Virginia owned by three not-for-profit health care providers: WVU Health System, Marshall Health Network, and Valley Health. Peak Health Insurance Corporation is a licensed health plan in the State of West Virginia.

At the time of the submission, Peak Health is a PPO network available to large and small employer groups where the employer directly pays for employee claims processed by Peak. Peak is preparing to offer PPO plans where Peak is responsible for directly paying claims for large and small employer groups.

Peak does not offer a standalone vision or dental plan currently.

Network Adequacy Standards

Peak Health meets standards set by the state of West Virginia. These standards ensure West Virginians have adequate participating healthcare providers. During this process, Peak Health takes into consideration the number of enrolled members, expected use of services, and their health needs. Each year Peak Health monitors its network to ensure it continues to meet standards. If any change occurs to providers in the network Peak Health will make sure the directory is updated.

Peak Health updates directory information of doctors, other healthcare professionals, and facilities like hospitals when they send us new information. The directory is updated three times per week. Hospital and facility accreditation details are updated when they expire. We check a practitioner's training, board certification, and license during our credentialing and recredentialing process.

To limit network adequacy issues, Peak Health also uses Aetna's First Health Complementary network. Using both the Peak Health Network and the First Health Complementary Network ensures members have greater access to participating healthcare providers in areas needing growth, such as Mercer, Raleigh, and Mingo counties. Members can schedule appointments with Aetna's First Health Complementary Network providers without first obtaining an authorization or

referral.
Peak Health regularly checks to see if the network meets members needs. Peak Health uses reports from inside and outside the company to see how services are used by its members. This helps Peak quickly find and focus on the right providers by county and specialty. Once providers are identified Peak Health's team of contractors reach out to get providers to join the network.

Peak Health will notify the state of West Virginia of any material changes to its Network Access Plan. The Peak Health Access Plan is available to members and the public on the Peak Health website https://peakhealth.org/ including any marketing materials.

Covered persons receive a Certificate of Coverage. This document includes a description of the members' rights and responsibilities.

All Peak Health benefit plans include unlimited access to telemedicine and telehealth. These services are available through both contracted national companies and individual providers. This improves member access to care from the comfort of home.

Peak Health has a wide variety of primary care, specialists, and hospitals in its network. When building its network, Peak considers where members live and receive care. Peak Health identifies available providers from local and national associations/boards of medicine and psychiatry, along with member and provider requests and utilization of non-participating services. Peak Health has a team of Contractors who uses the information to reach out and talk to providers about joining the Peak Health Network.

To help with access issues, Peak Health uses Aetna's First Health Complementary network. Using both the Peak Health Network and the First Health Complementary network ensures members have greater access to participating healthcare providers in the state and while traveling throughout the country. Members can schedule appointments with Peak Health and Aetna's First Health Complementary network providers without first obtaining an authorization or referral. To meet current WV adequacy wait time standards of 90 percent, Peak members can schedule appointments with behavioral health providers within 10

business day, routine primary care within 15 business days and non-urgent specialty care within 30 business days. If a member needs to see a provider and no in-network provider meets the network adequacy and access standards, Peak will make best efforts to arrange care with a qualified, available provider of the same specialty within the required time and distance. This ensures the member receives medically necessary, covered services at their in-network benefit level. For urgent needs, our Concierge Director is available to assist with member scheduling.

During ongoing network assessments, a report identifying non-participating providers and providers practicing in adjacent counties. Peak Health reaches out to the providers for recruitment into the Peak Health Network. If a provider agrees to join the network, the Peak Health Contractor obtains a complete signed contract including all credentialing materials for processing. If recruitment efforts are not successful, alternative arrangements including telemedicine are available for members to receive covered services.

Other arrangements implemented to address issues with care include healthcare provider recruitment and authorization of covered services to non-participating providers due to access issues. Peak recognizes that certain deficiencies may exist within its Network and has established procedures to address them. Members may request an exception based on this by reaching out to Member Service. Peak will review exceptions to determine if an available, like-specialty participating provider is accessible within the established time and distance standards set by the state. If an in-network provider is available, the member will be contacted by phone, letter, or member portal. Peak will offer to help contact the in-network Provider(s).

If the review determines there is no Peak in-network provider, the request will be reviewed for medical necessity and benefit coverage. Peak products may limit out-of-network benefits or approve only on an exception basis, except for emergency care. If the request meets the requirements, it will be approved, and the member notified by telephone, letter, or member portal.

If approved, the claim will be processed so that the members' deductible, coinsurance, and cost sharing will be no greater than if the provider had been

in-network. The member always has the right to choose where to get services. They can contact Member Service at the number on their insurance card to review their benefits.

The Network Deficiency Exception Process will be outlined in the member Certificate of Coverage. It will instruct members on how they can request services at in-network benefit level in the event of Network deficiencies.

For help finding a participating healthcare provider, Peak Health Member Service is available to assist by calling the number on the back of the member identification card. The Member Service team is trained and equipped to help people who have trouble reading or speaking English. Peak's network has a wide range of primary care, specialist, and facilities in network. This incorporates ECP, Essential Community Providers, who are critical to providing care and located throughout the state, such as Mental Health and Infectious Disease providers, inpatient hospitals, rural emergency hospitals, Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC). When building its network, Peak considers where members live and receive care. Peak Health identifies available providers from local and national associations/boards of medicine and psychiatry, along with member and provider requests and utilization of non-participating services.

Peak Health regularly tracks how long it takes for members to schedule and see a provider. This includes primary care, behavioral health, and specialty providers. The goal is to make sure participating providers meet the needs of members. Members may seek care from any provider of their choosing. Peak Health works to contract with qualified providers in the same specialty. Part of this is verifying credentials through primary sources during credentialing and recredentialing. This includes checking education, training, board certification, licenses, malpractice history, sanctions, liability insurance, and hospital privileges.

The Peak Health Provider Directory is regularly updated and available to the public. Peak Health Call Center will assist members in finding a Network provider. Peak Health utilizes Aetna's First Health Complementary Network inside and outside our service area to ensure members have available alternatives for access

to care without restrictions nor referrals required. If a member's benefit plan does not include out-of-network coverage and the member believes there is an adequacy issue, the member can ask in writing for an exception to have the services paid as in-network. Peak Health works to contract available, qualified, like-specialty providers to meet the needs of our members.

As a PPO plan, members do not need to choose a primary care doctor. They also do not need a referral for an appointment with a provider. To see what services would need approval, visit the Peak Health Prior Authorization List. It is found at www.peakhealth.org under Peak Provider > Policies > Prior Authorization List.

As a PPO plan, member benefits for services outside of the network vary based on out of network benefit.

Peak Health has set up clear policies to manage quality of care issues. We are committed to making sure our members get care that is safe, effective, and high-quality. To support the best health outcomes, we monitor, review, and track all care concerns. Peak Health follows standards from the Centers for Medicare and Medicaid Services (CMS) and National Committee of Quality Assurance (NCQA) standards.

Quality of care may involve problems like misdiagnosis, delays in care, or refusal to provide the services needed. They can also include issues with ongoing care, provider mistakes, or poor results from treatment. A quality-of-care issue happens when the care given does not meet national or local standards or current medical knowledge.

When a concern is found, Peak Health works with the provider on a plan to fix the issue. For urgent needs, our Concierge Director is available to assist with member scheduling.

Coordination and Continuity of Care

Peak Health offers Transition of Care (TOC) and Continuity of Care (COC) in special cases. These help eligible members keep seeing their provider, whether in-network or out-of-network, for a set time. TOC applies to new members who are already getting treatment when they join a Peak Health plan. COC applies when a

provider leaves the network, and the member cannot safely switch to a new provider right away. If approved, both TOC and COC let members continue care for serious health needs without needing new prior approval.

To meet current WV adequacy wait time standards of 90 percent, Peak members can schedule appointments with behavioral health providers within 10 business day, routine primary care within 15 business days and non-urgent specialty care within 30 business days. If a member needs to see a provider and no in-network provider meets the network adequacy and access standards, Peak will make best efforts to arrange care with a qualified, available provider of the same specialty within the required time and distance. This ensures the member receives medically necessary, covered services at their in-network benefit level. For urgent needs, our Concierge Director is available to assist with member scheduling.

Peak Health Medical Management Department assesses the needs of members including, but not limited to children and adults, persons with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical/mental disabilities, serious/chronic/complex medical conditions with all Care Management activities.

When coverage begins, members get a Certificate of Coverage. This document explains how to file an appeal or complaint. Members also receive this information with any denial of coverage.

The Peak Health Medical Management team looks at the needs of all members. This includes children, adults, and people who have trouble reading or speaking English. It also includes people from different cultures or backgrounds, and those with physical or mental disabilities. Members with serious or long-term health problems get help through Care Management.

If Peak Health denies a request or claim, members will receive notification. This notice explains why the request was denied and how to ask for more information. Peak Member Certificate of Coverage includes details on Peak's grievance and appeal procedure. This also details benefits and services covered to members. This can be viewed by logging into a member's MyPeak account.

Peak Health has a Support for Social Needs (SFSN) Program to help members who face social challenges that affect their health. These challenges may include trouble getting food, housing, transportation, or other basic needs.

For a member that shows signs of social needs through a screening, the program connects them to local or faith-based groups that can help. A Medical Management team member talks with the member to understand their needs and find the right support.

Peak Health helps members move smoothly from one care setting to another. This can lower the chance of problems, reduce return visits, and support better recovery. After a hospital stay, rehab, nursing care, or emergency room visit, Peak Health may call the member. These calls help make sure care continues and recovery stays on track. This process is called a Transition of Care Call.

The goal is to reach all members after they leave a care setting. These calls are part of Peak Health's effort to support members during recovery and help them stay well.

Health Carrier Insolvency

In the event of contract termination, Peak Health's insolvency, or other inability to continue operations, Peak Health will follow insolvency laws. Those directly affected will be informed.

Network Access Plan

With initial coverage, covered persons are provided a Certificate of Coverage. This document includes a description of the appeals and complaints / grievance procedure. In addition to the Certificate of Coverage, the appeals and grievance procedure is included with any adverse determination.

If a member's prior authorization request or claim is denied by Peak Health, the member will receive a written notice outlining the specific reasons for the decision, references to any applicable guidelines or plan rules, and instructions on how to request a copy of these materials at no cost. The notice will also explain what further information, if any, is needed to approve the request and detail the

process and deadlines for filing an appeal. If the denial involved medical judgment, the member may request an explanation of the clinical reasoning behind the decision.

The member has the right to appeal the decision and must do so within 180 days of receiving the denial notice. Appeals can be sent by mail, fax, or the member portal, or, if urgent, by phone. During the appeal process, the member may appoint an authorized representative to act on their behalf, provided Peak Health receives written notice of that authorization. Once submitted, the appeal will be reviewed by someone not involved in the original decision, and all supporting evidence will be considered, whether it was part of the original review or not.

A complaint can be made orally or in writing, while a grievance is a more formal written dispute not related to benefit denials. A disagreement with a benefit denial must be handled through the appeal process, not as a grievance.

Utilization management staff will make determinations of medical necessity in a timely manner to accommodate the clinical urgency of the situation and to satisfy all local, state, and federal regulatory requirements.

Peak Health is a licensed PPO plan and does not require members to select a PCP. Peak Health does not place any requirements on Members with respect to choosing or changing a provider. Members are not required to choose a primary care provider and are also not required to obtain referrals before seeking treatment.

Provider Directories

The public can view a current and accurate Peak Health electronic directory online at http://www.peakhealth.org under Find a Provider.

Peak Health electronic directories include a date showing the most recent update. Peak Health print directory disclosure includes date of printing, accuracy based on the information provided to Peak and a Member Service telephone number.

Peak Health responds within five business days to requests from a covered person

or prospective covered person for a copy of the Peak Health directory. The directory will be available in electronic format and print format when requested.

There is a tool on the website that a provider, member or the public may use to notify Peak Health of a possible error within the provider directory. The directory has a link to provide information on the sources used.

Peak Health ensures equitable access to services for members with limited English proficiency, varying literacy levels, diverse cultural and ethnic backgrounds, and physical or mental disabilities through our language access and non-discrimination plan. The Member Service Call Center is trained and equipped to assist.

Peak Health updates directory information of doctors, other healthcare professionals, and facilities like hospitals when they send us current information. The directory is updated three times per week. Hospital and facility accreditation details are updated when they expire. We check a practitioner's training, board certification, and license during our credentialing and recredentialing process.

Peak Health and or its delegates conduct at least quarterly audits of data and providers contained in the directory. The audit ensures our goal of complete accuracy.