ONE TOWER SQUARE
HARTFORD CT 06183

**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

EXTENSION OF INFO PAGE-SCHEDULE WC 00 00 01 (A)

POLICY NUMBER: UB-6N259033-22-14-G

INSURER: TRAVELERS PROPERTY CASUALTY COMPANY OF AMERICA

INSURED'S NAME: CHAMPLAIN COLLEGE INCORPORATED 13579-WV

RATE BUREAU ID: 911451999

EXP. MOD. EFFECTIVE DATE: 02-15-22

CLASSIFICATION	CODE	PREMIUM BASIS ESTIMATED TOTAL ANNUAL REMUNERATION	RATES PER $100 OF REMUNERATION	ESTIMATED ANNUAL PREMIUM
LOCATION 001 FEIN 030220266 ENTITY CD 001 00 CHAMPLAIN COLLEGE INCORPORATED WV- NO BUSINESS LOCATION				
COLLEGE: PROFESSIONAL EMPLOYEES & CLERICAL	8868	IF ANY	0.19	0

WV MANUAL PREMIUM $ 0

TOTAL PREMIUM SUBJECT TO EXPERIENCE MOD.	$	0
EXPERIENCE MODIFICATION:0.65 MODIFIED PREMIUM		0
TOTAL ESTIMATED ANNUAL STANDARD PREMIUM		0
-4.60% PREMIUM DISCOUNT(0064)		0
TOTAL ESTIMATED PREMIUM		0
5.00% REGULATORY SURCHARGE		0
0.55% FIRE AND CASUALTY SURCHARGE		0
TOTAL PREMIUM		0
DEPOSIT AMOUNT DUE		0

TRAVELERS
ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-6N259033-22-14-G

MANAGED CARE PROGRAM ENDORSEMENT

This endorsement applies only to the insurance provided by this policy for the states listed in the schedule below.

This endorsement provides for the payment of benefits under the Workers' Compensation law for medical services and health care to injured workers for compensable injuries and diseases by means of a MANAGED CARE PROGRAM which meets the requirements established by the state. Managed Care Programs are approved on a county by county basis in most states. As an employer you have a responsibility to your employees to comply with the requirements of each county as applicable.

SCHEDULE

Item #1 (STATES)

WV

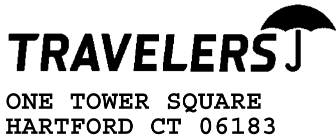
This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective Policy No. Endorsement No.

Insured Premium $

Insurance Company Countersigned by ____________________



ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-6N259033-22-14-G

WEST VIRGINIA EMPLOYERS LIABILITY ENDORSEMENT

This endorsement applies only to work in the state of West Virginia.

Part Two (Employers Liability Insurance), C. Exclusions is changed by adding these exclusions.

This insurance does not cover:

13. bodily injury to an employee when you are deprived by common law defense or are subject to penalty because of your failure to secure your obligations under the Workers Compensation law of West Virginia or otherwise fail to comply with the law.

14. bodily injury for which you are liable under West Virginia Annotated Code 23-4-2(d)(2)(A).

However, this exclusion does not apply to any bodily injury for which you are liable arising out of West Virginia Annotated Code 23-4-2(d)(2)(B).

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective　　Policy No.　　Endorsement No.
Insured　　Premium $

Insurance Company　　Countersigned by ______________________________

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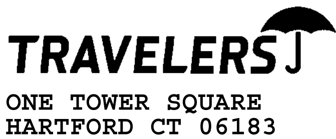

ONE TOWER SQUARE
HARTFORD CT 06183

POLICY NUMBER: UB-6N259033-22-14-G

WEST VIRGINIA CANCELLATION ENDORSEMENT

This endorsement applies only to the insurance provided by the policy because West Virginia is shown in Item 3.A of the Information Page.

Part Six, D (Conditions – Cancellation) is replaced by:

D. Cancellation

1. You may cancel this policy. You must mail or deliver advance written notice to us by stating when the cancellation is to take effect.
2. We may cancel this policy at any time by providing you thirty (30) days advance written notice.
3. Not withstanding #2 above, if you fail to pay any premium due or refuse to comply with a premium audit under this policy, we may cancel the policy by providing you ten (10) days advance written notice.
4. We may also choose not to renew this policy by providing sixty (60) days advance written notice.
5. Our mailing of the Notice of Cancellation or Non-Renewal to your mailing address as listed in Item 1 of the information page will be sufficient notice of our intent to cancel. We will also provide notice of the cancellation or non-renewal of the policy to the West Virginia Insurance Commissioner at least ten (10) days prior to the effective date of the termination, within ten (10) days of receipt of your request for cancellation, as applicable.

This endorsement changes the policy to which it is attached and is effective on the date issued unless otherwise stated.

(The information below is required only when this endorsement is issued subsequent to preparation of the policy.)

Endorsement Effective Policy No. Endorsement No.
Insured Premium $

Insurance Company Countersigned by ______________________

West Virginia
Workers Compensation
Managed Health Care Plan

Inside:

- Employer Information
- Employee Handbook
- Employee Rights and Responsibilities
- Employee Grievance Form
- Employee Satisfaction Survey

Employee Handbook including the Important Information for Employees, Rights and Responsibilities, Grievance form and Identification Card are to be shared with each employee at time of injury. The other informative materials can be used at your discretion.

W47N1I20
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Dear Employer:

Thank you for taking an active role in helping manage your workers compensation exposures. The enclosed kit of information is designed to give you basic knowledge of your Workers Compensation Managed Health Care Plan ("MHCP"). The West Virginia Offices of the Insurance Commissioner has approved the Travelers Managed Health Care Plan.

The MHCP encourages you to ensure that your Employee's choose a treating doctor participating in the MHCP. By taking an active role in ensuring the use of the MHCP, you may be able to expedite medical recovery for your injured employees and reduce lost time days.

The enclosed materials will help you make effective use of the MCHP. The Network Directory is an important part of this managed health care plan.

You should:

1. Determine the Treating Doctors or occupational clinics available near your work-site by reviewing the Directory.
2. Doing so in advance will make it quick and easy to assist in finding appropriate medical care for the Employee should a work-site injury occur.
3. Direct the Employee to choose a treating doctor from the Directory when a work-related injury occurs.
4. Complete a copy of the Request for Medical Treatment form enclosed in this kit and give it to the injured Employee to take with him/her to the treating provider.
5. Please provide a copy of the Employee Handbook listed below, to all employees at the time of their injury.

Providers within the Network are experienced in Workers Compensation and have contractually agreed to comply with West Virginia Workers Compensation Law. It is in everyone's best interest to return your Employee to work as soon as it is medically appropriate. The availability of modified and/or transitional duty programs at the work-site is key to this approach.

We have enclosed the following materials for your use:

1. What To Do When An Employee Reports An Injury
2. How To Find And Use The Network Directory
3. Request For Medical Treatment Form
4. Employee Handbook
    * Important Information for Employees
    * Grievance Form
    * Employee ID Card
5. Employee Satisfaction Survey

If you have any questions on the enclosed materials, please do not hesitate to call me at 1-866-336-8222. Your active role can mean better control of your Workers Compensation costs.

Sincerely,

Managed Health Care Plan Administrator

Enclosures

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What To Do When An Employee Reports An Injury

When emergency medical attention is required, send the injured employee to the nearest medical facility and contact the telephone reporting center at 1-800-832-7839 for national accounts, and 1-800-238-6225 for commercial, construction, and select accounts.

When an employee reports an injury not requiring emergency treatment, the following steps should be observed:

1. **GATHER INFORMATION REGARDING THE INJURY**

   Ask the injured employee how, when and where the injury occurred, and if there were any witnesses.

2. **CONTACT TELEPHONE REPORTING CENTER TO REPORT THE CLAIM**

   Upon direction from the Claim Adjuster, send the injured employee for medical treatment. Remember: If this is a medical emergency, direct the employee to seek medical attention immediately and then follow-up with this call.

3. **COMPLETE THE EMPLOYER'S REPORT OF INJURY OR EMPLOYER'S REPORT OF OCCUPATIONAL DISEASE.**

   It is important to complete and file paperwork as soon as possible. WV code 23-4-1b requires you to complete and submit the form within 5 days of receipt of the notification of the employee's injury.

4. **PROVIDE NOTIFICATION DOCUMENTS TO EMPLOYEE**

   Upon notice of an injury, provide the employee Managed Health Care Plan Handbook and completed ID Card.

5. **DIRECT THE INJURED EMPLOYEE TO CHOOSE A TREATING PHYSICIAN.**

   When emergency medical care is required – If your employee sustains a life-threatening injury or an injury that could cause further medical complications, dial 911, and have your employee transported to the nearest emergency medical center. Under the MHCP, the emergency medical facility does not have to be a Plan provider.

   If your employee sustains an injury or disease that is not life threatening and does not pose the risk of causing further injury, direct your employee to a primary medical care facility. If a facility is not available within 75 driving miles of your physical location, the employee may be treated at a facility outside the network. You may find a list of facilities in your area at www.Travelers.com/injuredemployee or by contacting the MCHP at 1-866-336-8222.

6. **COMPLETE AN EMPLOYEE INTRODUCTION LETTER**

   Fill in a copy of the Request For Medical Treatment Form with the appropriate information. Give the completed Request for Medical Treatment Form to the injured employee and advise him/her to give the letter to the provider he/she has chosen as his/her Treating Provider before treatment is initiated.

7. **ARRANGE FOR THE EMPLOYEE TO BE TREATED BY A PROVIDER WITHIN THE NETWORK**

   Either you, the Medical Case Manager, or the Claim Adjuster should contact the Provider to advise that they are on their way or arrange an appointment for treatment of the injured employee.

8. **FOLLOW-UP AND RETURN-TO-WORK**

   Work with the assigned Medical Case Manager, Claim Case Manager, and the Treating Provider to return the employee to either light or full duty. Evaluate any restrictions and offer modified duty if applicable.

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9. PHARMACY BENEFITS

If the employee requires pharmacy benefits, send them to the nearest Plan pharmacy along with the MHCP Identification card provided within this packet. Under the plan, regardless of the disposition of the claim, the employee is eligible for a guaranteed first fill of his/her pharmacy benefit with no out-of-pocket cost. In the event the claim is rejected, you will not be responsible for payment. In the event the employee pays for a prescription related to his or her industrial injury, submit the receipt along with the details of the prescription to case manager assigned to the claim.

10. QUESTIONS

If you have any questions relating to this MHCP, please contact the Plan at:

Writing:	Travelers P.O. Box 4614 Buffalo, NY 14240-4614 Attn: Managed Care Plan Admin.
E-Mail:	WVMHCP@travelers.com
Calling toll-free:	1-866-336-8222

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How to Find and Use the Network Directory

1. For those who have Internet access, use of the www.Travelers.com/injuredemployee web page can provide access to selection of network providers. Otherwise please contact the MHCP for a provider directory.

2. Review the list of providers in the area to determine the nearby treating providers or occupational clinics. Doing so in advance will enable you to be prepared in the event a work- site injury occurs.

3. Make sure your staff has access to the provider listings and explain to them how easy it is to use providers in the Network. Provider names, addresses, and telephone numbers are readily available with driving directions on the web site.

4. Advise the staff that use of the network providers is mandatory except in emergency situations. The providers participating in the Network meet specific quality standards and credentials and are experienced in treating work-related injuries and illnesses.

5. In non-emergency situations, complete the Request for Medical Treatment Form for the injured employee. Instruct the employee to bring the form with them to present to the treating provider. The Request for Medical Treatment form explains to the provider that the employee is a participant in a Managed Health Care Plan.

6. If you have any questions concerning the use of the Network, please call the Workers Compensation Managed Health Care Plan at 1-866-336-8222.

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Workers Compensation Managed Health Care Plan
Request For Medical Treatment Form

Part 1: (To be completed by Supervisor. Please Print.)

Employee Name:________________________ Social Security Number:____________________

Date:________________________________ Supervisor Name:__________________________

Employer Name:________________________ Supervisor Phone Number: __________________

Employer Address:____

Date of Injury:________________________ Place of Injury:__________________________

Injury Description:____

Part 2: (To be completed by Employee. Employee should take this form to the treating physician.)

I authorize payment directly to the provider for the medical services rendered and I authorize the release of medical information to Carrier/Claim Administrator or its designee for medical review.

Employee Signature:________________________ Date:__________________________

***Note* By providing this form to the Employee, neither the Carrier/Claim Administrator nor the Employer concede compensability or eligibility of the injury described above under the applicable Workers Compensation laws.**

Part 3: (To be completed by treating physician. Please print.)

The physician should complete this information, give one copy to the Employee (to return to the Employer), attach one copy to your itemized bill and medical report to the Carrier/Claim Administrator, and keep third copy for your records.

I have treated______________________for______________________and found that he/she:
(Employee Name) (Medical Condition)

[ ] Is able to return to his/her present job

[ ] Can return to modified duty with the following restrictions:______________________

[ ] Cannot return to work at the present time. Estimated period of disability:__________________

[ ] Follow-up with me in_____days or_____weeks, and/or referral to:____________________

[ ] Other comments:____

Physician Name (Please Print):____

Physician Signature:______________________________ Date:________________________

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Part 4: (Important information for Medical Providers)

Pursuant to Title 85-21, the West Virginia Offices of the Insurance Commissioner established the requirement and procedures to be followed by the Commission, parties to claims before the Commission, employers, and managed health care plan administrators and others involved in the delivery or proposed delivery of managed care to the injured worker pursuant to W. Va. Code §23-4-3(b)(2).

The goal of Managed Health Care Plans is to assist workers to return to work as soon as practicable after a compensable injury and to otherwise provide for high quality, cost effective medical care to the injured worker. The following information being provided to you is to assist you as a medical provider to ensure compliance with the rules. This Employer is covered by a Managed Health Care Plan (MHCP) that has been approved by West Virginia Offices of the Insurance Commissioner.

The MHCP provides the following features:

1. A preferred provider network, which provides access to medical facilities and providers throughout the state. The network provides injured employees with a reasonable choice of providers, including adequate specialty and subspecialty providers, and general and specialty hospitals.
2. No co-payments or deductibles. All approved treatment will be paid under The Plan in accordance with West Virginia's state fee schedule and preferred provider rates. Injured employees will never have to pay a co-payment or deductible for approved treatment.
3. A claim adjuster and medical case manager to assist injured employees in obtaining proper medical care to help in their recovery and prompt return to work. They can be reached at **1-866-336-8222.**
4. Injured workers rights, responsibilities and confidentiality policies are provided to all injured workers and providers.
5. A pharmacy benefit program, which provides a network of pharmacies throughout the state and allows injured employees to obtain approved pharmaceuticals hassle-free, with no out-of-pocket expense.

Upon review by the MHCP, an employee may seek treatment outside network under the following conditions:

1. For emergency care when access to a health care provider within The Plan is unobtainable for the acute phase of care;
2. When authorized treatment is unavailable through The Plan;
3. To obtain a second opinion when a plan physician recommends surgery and another qualified physician within The Plan is not available for consultation; or
4. Establish by competent evidence that all of the following applies to their care:
   a. The employee has been treated by providers solely within The Plan for a period of at least one (1) year.
   b. For reasons related to the employee's treatment alone, he or she has not made progress toward recovery that is reasonably consistent with the Commission's treatment guidelines.
   c. The employee establishes, to a reasonable certainty, that proposed treatment outside The Plan would more likely provide him or her with a better clinical outcome than the current treatment or rehabilitation plan.

Part 5 (Claim Information)

1. Print the Employee's claim number or social security number and date of injury on any bills and reports. Bill only for services directly related to the injury listed above and submit itemized bill and medical report, along with a copy of this completed Request For Treatment Form, to the claim office.
2. Any person or entity who willfully and knowingly makes any material false statement or representation for the purpose of obtaining any benefit or payment, or for the purpose of defeating or wrongfully increasing or decreasing any claim for benefit or payment for workers compensation coverage, or who aids and abets for said purpose, may be subject to civil or criminal penalties, or both, imposed pursuant to applicable statutes and/or regulations.

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Important Information for Employees
Regarding Medical Treatment for a Work-Related Injury or Illness

Travelers

Managed Health Care Plan for Workers Compensation

You are being provided this handbook because you have sustained an injury. Your employer's workers compensation related medical care is being provided through a Managed Health Care Plan ("MHCP"). This program has been approved by the West Virginia Office of the Insurance Commissioner.

This notice describes the program and your rights in choosing medical care for work- related injuries and illnesses. Receipt of this handbook does not construe acceptance of your claim.

If you want information about the MHCP, you can contact the Plan Administrator by:

Writing:	Travelers P.O. Box 4614 Buffalo, NY 14240-4614 Attn: Managed Care Plan Admin.
E-Mail:	WVMHCP@travelers.com
Calling toll-free:	1-866-336-8222

The Plan Administrator will:

- Answer your questions about the MHCP;
- Help you find the names of MHCP providers within your area;
- Help you get an appointment with a MHCP provider if you are having trouble.

What is a Health Care Network (MHCP)?

An MHCP is a program that helps manage medical care for work-related illnesses and injuries. The MHCP requires you to use specific hospitals and doctors if you incur a work-related illness or injury.

Each MHCP is required to have enough participating hospitals and doctors near your employer's facility. These hospitals and doctors specialize in work-related injuries.
MHCP providers must meet quality standards and provide care according to standard treatment guidelines.

Where is the MHCP certified to operate?

The MHCP is certified in all counties.

What happens if I am injured at work?

If you have a work-related injury or illness that is:

- An emergency; or if you need emergency care after normal business hours, call 911 or go to the nearest emergency room or urgent care center regardless of whether or not the provider is an MHCP provider. **Notify your employer as soon as possible after any emergency treatment.** Your claim will not cover any payment for care provided outside the MHCP that is determined not to be emergency care.
- Not an emergency, notify your employer right away. The treating provider you choose must be from within the MHCP. If you need after hours care for a non- emergency, you can get a list of MHCP hospitals and urgent care centers by calling the MCHP; or by accessing a list on the website at www.Travelers.com/injuredemployee.

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What is an MHCP treating physician?

An MHCP treating physician is a doctor who will:

- treat you for your work-related injury or illness;
- coordinate all related care;
- refer you to any necessary specialist within the plan;
- participate in case management activities with the Plan; and
- provide maximum medical improvement and impairment ratings.

A treating physician can be a medical doctor, an osteopath, a podiatrist, or a chiropractor who has contracted to provide workers compensation treatment under the Plan.

How do I choose an MHCP treating physician?

You must choose a treating physician from the list of MHCP doctors that are within 75 driving miles of where you work.

If you need help in finding an MHCP provider, you can contact your Medical Case Manager ("MCM") or the MHCP Administrator at 1-866-336-8222 or log onto the website www.Travelers.com/injuredemployee. If you call the MHCP outside of normal business hours, you may leave a message and your call will be returned on the next business day. You can also ask your Employer for a copy of the MHCP provider list.

The list of MHCP providers is updated periodically. The provider list will provide you with the names and addresses of network providers grouped by specialty. All treating doctors are identified and listed separately from specialists.

MHCP contracted providers have agreed to look only to the MHCP for payment for the compensable medical care that they provide to you. You will not have to pay for medically necessary care you get from an MHCP provider related to your compensable work-related injury; nor will you be responsible for any deductibles or copays be required in order for you to receive care. However, if you receive medical care from providers who are not in the MHCP you may have to pay for that care.

What if I already have a workers compensation injury?

If you were injured at work before your employer participated in the MHCP you must choose a treating physician from within the network. All future care for your workers compensation injury must be provided by your new MHCP treating physician.

Can I change my MHCP treating physician?

If you want to change your treating physician, you must receive approval from the MHCP prior to receiving care by the new MHCP provider. You can call your MCM to request approval to change your treating physician.

You do not need approval to change your treating physician if:

- Care is transferred after an initial emergency or first aid treatment if done so within 30 days of the date of your injury;
- Your original treating physician transferred your care to a specialist; or
- You require care for an unforeseen emergency which requires special facilities and skills that are not available to your treating physician or hospital.

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What if my treating physician says I need services from a specialist?

Except for emergency services, your treating physician will provide all treatment related to your workers compensation injury. If necessary, your treating physician may refer you to an MHCP specialist. If you need help getting an appointment with the specialist, call the MHCP for assistance at 1-866-336-8222.

What happens if my treating provider leaves the network?

- If your doctor decides to leave the network, you will be notified via telephone and in writing by the MHCP. You must then select another doctor from the Plan.
- If your treating doctor is terminated by the MHCP, you will be notified in via telephone and in writing by the MHCP. If this happens you will have to select an alternate MHCP treating physician right away.

Under what circumstances can I treat with a provider who is not in the plan?

You may receive treatment from a non-network doctor with approval from the MHCP if:

- Your treatment is an emergency;
- You need medical services not provided by the MHCP;
- You would like a second opinion for a surgery recommended by a Plan provider and another Plan provider is not available for consultation; or
- There is competent evidence that you have been treated in the Plan for one year and you have not made progress toward recovery, and the proposed treatment would provide better clinical outcomes.

If any of these situations apply to you, call the MHCP at 1-866-336-8222 to request approval for non-network care.

Unless it is an emergency you should not obtain medical services outside of the MHCP without approval.

The MHCP will make a decision related to your request within 10 working days. If your request is denied you will be sent notice of the network requirements and you must choose a treating physician from the list provided to you. If you do not agree with the MHCP's decision, you may file a grievance in accordance with the MHCP Grievance Procedure.

While waiting for a decision to be made you must seek care from network providers. If you choose to receive medical care from outside the network, while you are waiting for a decision to be made, you may be required to pay for those health care services you received outside the Plan.

Services obtained outside the MHCP are for treatment purposes only. You must see a Plan provider to obtain an impairment rating.

What is the MHCP service area?

The MHCP provides access to primary treating providers or hospitals within 75 miles of your employer's facility; and access to specialists and specialty hospitals within a reasonable distance from the facility. If you think there are not enough providers or no appropriate providers within the mile range noted above for primary care or in a reasonable distance for all other care, contact the MHCP to request approval for non-network care and provide evidence to support your claim.

The MHCP will review your request and send you a written decision within 10 working days. While your request is being reviewed, you may choose to receive health care services from a non-network doctor. If you make this choice, you may be responsible for payment if it is found that there are appropriate providers within the MHCP service area. If it is found that there are appropriate providers within the service area and those providers are available to you, the MHCP will send you notice of the network requirements and you must choose a doctor from the list provided to you.

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Do any medical services require pre-authorization?

Yes. Medical care requires authorization from the MHCP before it can be performed. Your doctor will request that the MHCP pre-authorize those services. The MHCP will review treatment requests from your treating doctor against standard treatment guidelines to determine the medical necessity of the requested treatment.

What happens if my treating doctor's request for care isn't approved?

If any of your proposed medical care is determined not to be medically necessary, you will be notified in writing. This decision is called an adverse determination. The adverse determination notice will include instructions for submission of an appeal to the Plan. You must complete the adverse determination process before filing a grievance.

You receive a notice following any request for appeal stating the outcome of that review. If that notice upholds the adverse determination it will include instructions on how to request a grievance.

How do I file a complaint/grievance?

You and your providers have the right to file a complaint or grievance with the MHCP. A complaint or grievance can be filed regarding services provided by the MHCP or its network providers, within 30 days of the event or occurrence that is the basis for the complaint/grievance. Complaints or grievances must be filed in writing on the attached form to:

Travelers
P.O. Box 4614
Buffalo, NY 14240-4614

Attn: MHCP Grievance Coordinator

The MHCP Grievance Coordinator will review and render a written determination regarding the complaint within 30 days of receipt. A physician will be consulted in the determination process if the grievance is medically-related.

Be sure to include the following information in your request: your name; current physical address; telephone number; name and address of your provider; a description of the event or occurrence that is the basis of the complaint and any other information you feel would be helpful in making the determination.

If you disagree with the MHCP's resolution of your complaint, you may appeal the decision to the Office of the Judges within 60 days. You will be notified of the decision, and any written determinations regarding your medical treatment.

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West Virginia Workers Compensation Managed Health Care Plan

GRIEVANCE FORM

An Injured Worker or Health Care Provider should use this form to request a formal review regarding dissatisfaction with services, including medical care issues, provided by or on behalf of a Workers Compensation Managed Care Arrangement.

This Grievance is being filed by:

☐ Provider ☐ Family Member
☐ Injured Worker or a Designated Representative ☐ Attorney ☐ Other

Date of Injury:________________________________

INJURED WORKER'S / PROVIDER'S NAME: ____

Social Security Number: ____

Address:____

Home Telephone:________________________Work / Alternate Phone:________________________

Telephone number of the contact if other than injured worker or provider: ________________________

TREATING PHYSICIAN:____

Address:____

Office Telephone:____

Please describe your concern below. If you require additional space, continue your statement on a sheet of plain paper. Please be sure your name and social security number appear on each page of any attachment.

Why is this grievance being filed? (Nature of the problem):

____
____
____
____
____
____
____

Has a grievance been previously filed? ☐ YES ☐ NO. If YES, Date Sent? ________________

What action would you like to see taken?

____
____
____
____
____

W47N1I20

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INTENT: The grievance procedure is intended to be self-executing and easy to use. Please complete this form and send it to the address shown below. A review regarding the grievance will begin immediately, and a decision made within 30 days of receipt.

The injured worker's participation in the grievance process is important to the resolution of the issues. Individuals reviewing the grievance may need to speak directly with and receive input from the injured worker. If the injured worker is unable to participate actively in the grievance process, a patient advocate may participate on behalf of the injured worker.

If the injured worker, employer of carrier is dissatisfied with the final decision of the grievance committee, the dissatisfied party has the right to file a Protest with the WV Office of Judges as set forth in the West Virginia Code.

Any person who, knowingly and with intent to injure, defraud or deceive any employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Form Completed by:

______________________________	______________________________
Injured Worker/Provider/Other	Date Form Completed/Signed
______________________________	______________________________
Signature of Grievance Coordinator	Date Grievance Coordinator Signed

---

MAIL TO:

Workers Compensation Managed Health Care Plan Travelers
ATTN: GRIEVANCE COORDINATOR
P.O. Box 4614
Buffalo, NY 14240-4614

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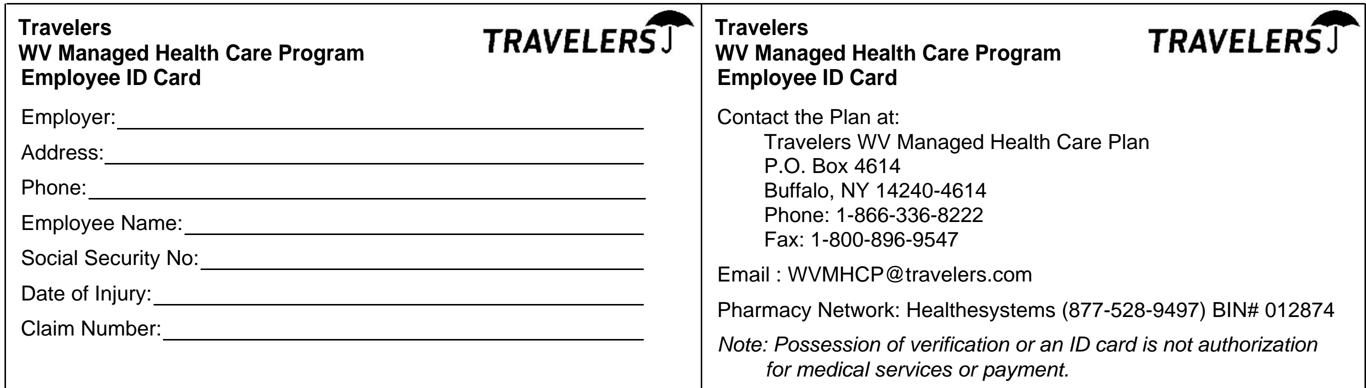
Employee ID CARD



Travelers
WV Managed Health Care Program
Employee ID Card

TRAVELERS

Employer:____________________
Address:____________________
Phone:____________________
Employee Name:____________________
Social Security No:____________________
Date of Injury:____________________
Claim Number:____________________

Travelers
WV Managed Health Care Program
Employee ID Card

TRAVELERS

Contact the Plan at:
Travelers WV Managed Health Care Plan
P.O. Box 4614
Buffalo, NY 14240-4614
Phone: 1-866-336-8222
Fax: 1-800-896-9547

Email : WVMHCP@travelers.com

Pharmacy Network: Healthesystems (877-528-9497) BIN# 012874

Note: Possession of verification or an ID card is not authorization for medical services or payment.

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Workers Compensation Managed Health Care Plan

Employee Satisfaction Survey

The form on the following page is a feedback mechanism for expressing results of medical treatment.

This feedback form is used by Travelers in a random survey process to determine satisfaction with the providers in the Workers Compensation network.

You, as an employer, may want to use this form when an employee:

- Expresses satisfaction with care that was provided
- Dissatisfaction with care that was provided
- Concerns about the facility/office
- Positive experiences with the facility/office

When an employee is dissatisfied please encourage them to provide their address on the survey in case it is necessary to make contact for additional information.

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Managed Health Care Plan

We want you to be satisfied with the medical treatment you have received as a participant in the Travelers Workers Compensation Managed Health Care Plan. We appreciate your input on the following:

____

(Name of Provider/Clinic)

(Please circle appropriate choice)

1. Was the clinic or office clean?
   - A. very clean
   - B. somewhat clean
   - C. dirty
   - D. very dirty
2. How long did you wait to be seen by the medical staff?
   - A. less than 20 min.
   - B. 30-45 min.
   - C. 45 min- 1 ½ hrs.
   - D. over 1 ½ hrs.
3. Were you treated with care and attention?
   - A. very much so
   - B. careful and attentive
   - C. not so careful or attentive
   - D. very inattentive
4. Did the medical staff explain your diagnosis and/or treatment plan?
   - A. very much so
   - B. explained somewhat
   - C. did not fully cover all issues
   - D. did not explain at all
5. Overall, were you satisfied with your visit?
   - A. very satisfied
   - B. somewhat satisfied
   - C. somewhat dissatisfied
   - D. very dissatisfied

ADDITIONAL COMMENTS:____

____

NAME:____________________________ DATE:____________________________

ADDRESS:__________________________ PHONE NUMBER:______________________

*****Please return this completed questionnaire via mail to:

Travelers

Attn: Managed Care Plan Administrator
P.O. Box 4614
Buffalo, NY 14240-4614

Or Fax to: 1-800-896-9547

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NOTICE TO EMPLOYEES

Notice is hereby given that the undersigned employer has secured the payment of compensation under the provisions of the West Virginia Workers' Compensation Law.

The Worker's Compensation insurance carrier/administrator for

CHAMPLAIN COLLEGE INCORPORATED

______________________________ is:

(employer name)

THE TRAVELERS INSURANCE COMPANIES

(name of carrier/administrator)

P.O. BOX 4614

(mailing address)

BUFFALO, NY 14240-4614

(city, state, zip)

(800) 238-6225

(telephone number)

____

(Name of employer contact person)

This notice must be posted and maintained conspicuously in and about the employer's workplace as required by West Virginia law.

West Virginia law requires that you notify your employer **immediately** upon sustaining a workplace injury.