# Welcome to AULTCARE

## At AultCare, *You* Matter!

Our commitment to teamwork, alongside our network providers and hospital systems, allows us to offer convenient, local, personalized care to our members. Through teamwork, we provide YOU with excellent customer service and quality cost-effective healthcare.

**We are here for *you!***

*Insured*
Administration Manual

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# 1 | Contact Information

## Sales and Retention Department

Company representatives* should contact the Sales and Retention Department to request new enrollment packets and for other issues not listed below.

**Phone | 330-363-6390**

**Fax | 330-363-7724**

## Service Center

Company representatives and employees should contact the Service Center for questions regarding benefits that your plan covers or an outstanding claim. An AultCare Service Representative is available Monday through Friday from 7:30 a.m. to 5 p.m.

**Phone | 330-363-6360 or 800-344-8858**

**Fax | 330-438-9804**

**Online Chat at AultCare.com**

## Billing Department

Company representatives may contact the Billing Department with questions regarding monthly invoices.

**Phone | 330-363-6360 or 800-344-8858**

**Fax | 330-363-5012**

**Email | aultcarebilling@aultcare.com**

## Member Services/Eligibility Department

Company representatives may contact the Member Services/Eligibility Department with enrollment questions.

**Phone | 330-363-6360**

**Fax | 330-363-7746**

**Email | aultcareeligibility@aultcare.com**

## Visit our website

**AultCare.com**

*** Company representatives are individuals authorized to request information on behalf of the company.**

# Employer Account Registration Guide

## Welcome

to our AultCare family. Whether you are a new client or have been with us for many years, we are proud to assist you in managing your employer account.

We have created an area on AultCare.com designed just for you. You can use the online account to retrieve monthly reporting and invoices, send us files, view your group's eligibility, order ID cards and more.

To get started, you and each authorized representative must register for a secure online account. Once you have created an online account, use this document to learn how to retrieve files from your online account.

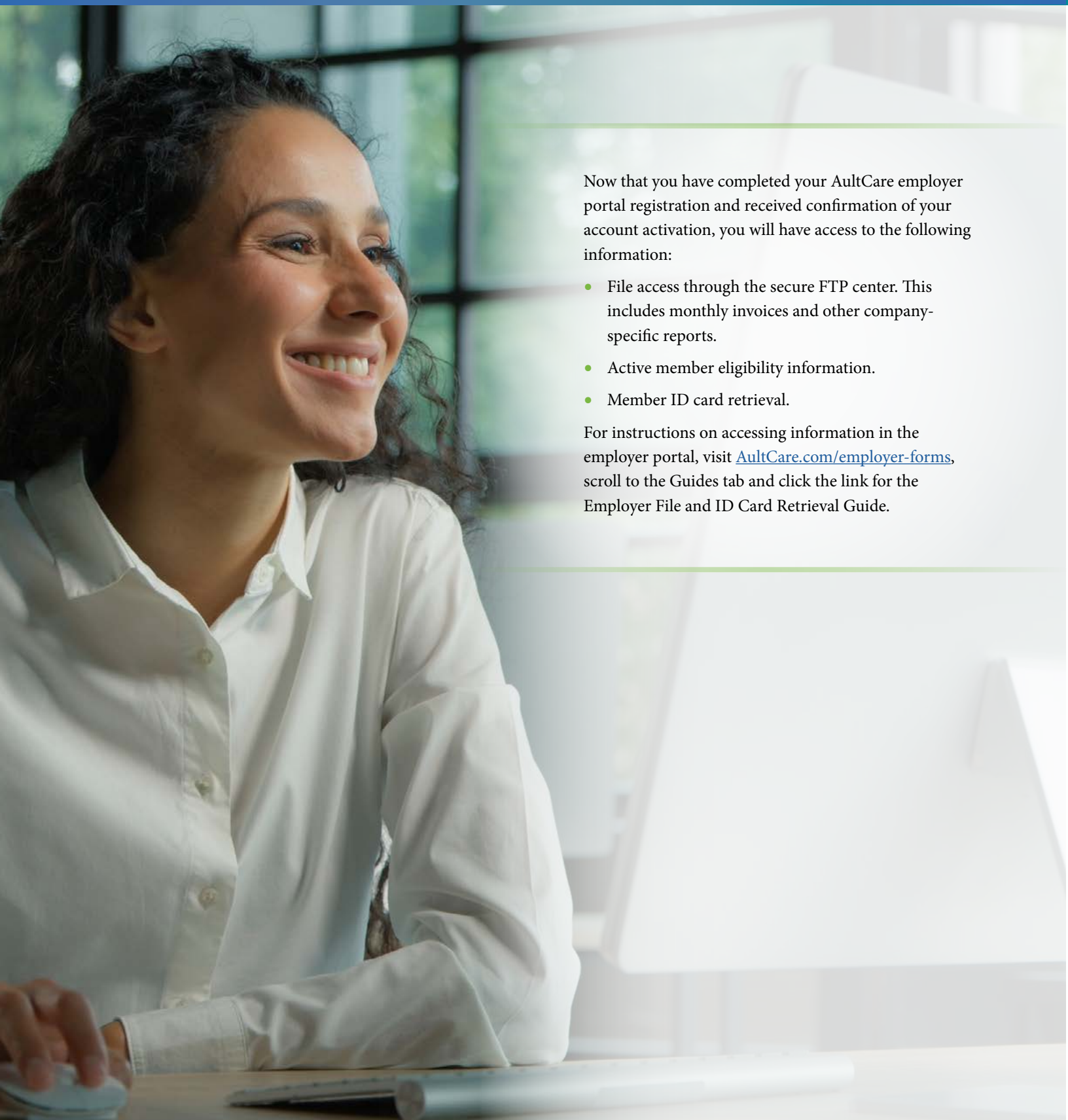
For complete instructions on setting up your account, please visit AultCare.com/employer-forms, scroll down to the Guides tab and select the Employer Online Account Registration Guide.

If you have questions, you can contact your account coordinator or account executive, or for technical assistance, email the AultCare web team at the Employer Contact Us Page.

***Thank you,***

*Your AultCare Team*

# Employer Portal Access



Now that you have completed your AultCare employer portal registration and received confirmation of your account activation, you will have access to the following information:

- File access through the secure FTP center. This includes monthly invoices and other company-specific reports.
- Active member eligibility information.
- Member ID card retrieval.

For instructions on accessing information in the employer portal, visit AultCare.com/employer-forms, scroll to the Guides tab and click the link for the Employer File and ID Card Retrieval Guide.

# 4 | *Enrollment Forms*

**The following information is provided to explain the process of enrolling and terminating employees and/or dependents. To ensure timely enrollment updates, please complete and return the Enrollment Application/Change Form or Cancellation and Continuation Form. If you would like information regarding electronic methods to complete enrollment changes, contact your account coordinator or account executive.**

## 1. Step-By-Step Guide

This guide was created to assist with the completion of the enrollment application/change form. The text denoted in red provides additional information to help understand what information is being requested.

## 2. Enrollment Application

All new employees and those employees requesting a change in their coverage must complete this entire form unless otherwise instructed. Spouse signature is required when waiving coverage.

## 3. Cancellation and Continuation Form

List all cancellations on this form. Utilize transaction codes for each change. Include enrollment form where indicated.

## 4. Important Information

All enrollment changes must be sent to AultCare within 31 days of qualifying event. Enrollment changes received before the 10th of the month will be reflected on the next monthly invoice.

Do not make enrollment changes on your monthly premium invoice.

**Return completed enrollment forms to:**

**Email:** aultcareeligibility@aultcare.com
**Fax:** 330-363-7746
**Mail:** AultCare Member Services

Questions may be directed to Customer Service 330-363-6360.

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# *Fully Insured Eligibility Fact Sheet*

- **Effective Dates:**
  - > Members effective on the first day of the month will be invoiced for the entire month.
  - > Members effective after the first of the month will not be invoiced until the following month.
  - > Members with an effective date and termination date within the same month will be invoiced for that month.
  - > Members with a termination date after the first of the month will be invoiced for the entire month.

- **Newborns:**
  - > Employee must enroll the newborn, and the employer must submit enrollment paperwork to AultCare within 31 days of birth.

- **Termination Dates:**
  - > Coverage ends on the end of the month the member terminates.
  - > Coverage for dependents turning age 26 ends on the end of month.

- **Reinstatement of coverage - Return to work rules:**
  - > Employers with 50 or more employees - Members may be reinstated on the plan within 13 weeks with no waiting period.
  - > Employers with less than 50 employees on a Transitional Relief Plan - Members may be reinstated on the plan within 14 days with no waiting period.

# *Guide for Completing the Enrollment Application/Change Form*

Please complete this form in its entirety.

## EMPLOYER USE ONLY

This section is to be completed by the employer representative.

**Employer Group Numbers**
List all AultCare group numbers that apply. (Medical, Dental, Vision)

**Employee Location/Job Classification**
Use this section to designate an employee classification, if needed. These designations should be set-up as rate codes during the implementation of your plan. (Example: hourly vs. salary; executive or management; physical plant location.)

**Leased Network**
Designate if the employee is accessing an out-of-area network. (Cigna, First Health Network, etc.)

**AultCare Effective Date**
Provide the date the coverage is set to begin.

## EMPLOYEE COVERAGE ELECTION

This section is to be completed by the employee.

**A) NEW POLICY APPLICATION**

**☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Waiving Coverage**
Designate the reason for applying for coverage or if coverage is being waived. If waiving coverage, a signature is required on the back of this form.

**☐Qualifying Event – Explain:**
If applying for coverage for a qualifying event, please provide a detailed explanation. (For example: spouse lost coverage, marriage, birth, adoption.)

**Hire Date**
If the original hire date is not available, please provide the month and year.

**Coverage Type(s) Requested:**
**Check All that Apply ☐Medical ☐Dental ☐Rx ☐Vision ☐STD ☐Life ☐Flex ☐HSA ☐HRA**
Be sure to check all benefit options being elected.

**Plan Requested: Plan Name**
Use this section to designate the employee's plan election. (Example: PPO, HDHP or OPT 1, OPT 2, etc.)

## ADDITIONAL COVERAGE FOR DEPENDENTS

This section is to be completed by the employee.

**A(dd), C(hange), D(elete)**
Please provide the reason code for enrolling or disenrolling dependents.

**Social Security Number**
SSN are required for all dependents with coverage.

**Benefits Selected (M,D,V,R)**
List all that apply.

**Other Insurance Coverage? (Y/N)**
If yes, please complete the other coverage information on the back of this form.

## OTHER COVERAGE INFORMATION

This section is to be completed by the employee if any covered persons have other health insurance coverage.

## MEDICARE INFORMATION

This section is to be completed by the employee if any covered persons are enrolled in Medicare.

## OTHER INFORMATION

This section is to be completed by the employee to designate any specified needs.

**All Employees**
Signature_____ Date _____
Employee must sign and date when electing coverage.

**Employees Waiving Coverage**
Reason for waiver of coverage: _____
Employee and spouse must provide reason for waiving coverage.
Signature_____ Date _____
Employee and spouse must sign if either are waiving coverage.

**Please submit this form to AultCare by one of the following methods:**
Email: aultcareeligibility@aultcare.com |
Fax: 330-363-7746 | Mail: AultCare Member Services
PO Box 6910 Canton, OH 44706
Employer to send completed form to AultCare by one of the following methods.

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# Enrollment Application/Change Form

**without Medical Questions**

| AULTCARE USE ONLY | |
|---|---|
| Date Completed | Completed By |
| Card Sent | |

| EMPLOYER USE ONLY | | |
|---|---|---|
| Employer Name | | Employer Group Numbers |
| Employee Location/ Job Classification | Leased Network ☐Yes ☐No | AultCare Effective Date |

## EMPLOYEE COVERAGE ELECTION

**A) NEW POLICY APPLICATION** ☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Waiving Coverage

☐You Only ☐You & Your Spouse ☐You & Your Child(ren) ☐You, Your Spouse & Your Child(ren)

☐Qualifying Event – Explain: _____

Date of Qualifying Event _____

(Qualified enrollment must be made within 31 days of event)

| **B) EMPLOYEE INFORMATION** | Last Name | First Name | | Suffix |
|---|---|---|---|---|
| Sex ☐Male ☐Female | Date of Birth | Social Security Number | | |
| Home Address (Number & Street) | | County | City | Middle Initial / State / Zip Code |
| Preferred Phone Number | Address | | | |
| Marital Status ☐ Married – Date of Marriage | Email | ☐Single ☐Widowed ☐Divorced ☐Separated | | |
| Employment Status ☐Full Time ☐Part-Time ☐Retired ☐COBRA | Currently on Hire | Hours Worked Per Week | Are you currently actively at work? ☐Yes ☐No If not, why? _____ | |
| Coverage Type(s) Requested: Check All that Apply ☐Medical ☐Dental ☐Rx ☐Vision ☐STD ☐Life ☐Flex ☐HSA ☐HRA | | | Plan Requested: Plan Name _____ | |

## ADDITIONAL COVERAGE FOR DEPENDENTS

Date

| A(dd), C(hange), D(elete) | Relationship to Enrollee | First Name | M.I. | Last Name (If different from employee) | Social Security Number | Benefits Selected (M,D,V,R) | Sex (M or F) | Date of Birth | Other Insurance Coverage? (Y/N) |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

M - Medical D - Dental V - Vision R - Prescription

## IMPORTANT INFORMATION

**OTHER COVERAGE INFORMATION**

Upon your effective date with this plan, will you or any of your family members have other health insurance? ☐ YES ☐ NO

If yes, what is the name of the other insurance company?

If yes, what type(s) of other health insurance will you have? Check all that apply ☐ Medical ☐ Dental ☐ Rx ☐ Vision

**MEDICARE INFORMATION**

Do you or your spouse or any enrolled dependents have Medicare coverage? ☐ YES ☐ NO If yes, please provide information below.

| Medicare Enrollee Name | Medicare ID Number | Hospital Effective Date (Part A) | Medical Effective Date (Part B) |
|---|---|---|---|
| | | | |

Do you have Medicare Part D coverage? ☐ YES ☐ NO If yes, what is the effective date of your coverage?

**OTHER INFORMATION**

Do you, or any of your dependents, have any cultural or linguistic needs? ☐ YES ☐ NO

If yes, what are they?

**Ethnicity:** ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Choose not to answer

**Race:** ☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Choose not to answer

**Language:** ☐ English ☐ Spanish ☐ Other _____

## RELEASE OF INFORMATION/PLEASE READ CAREFULLY

I am applying for group health coverage through AultCare Insurance Company and its related entities ("AultCare"). I acknowledge the coverage for which I am applying is subject to eligibility requirements and the terms of the policy. I acknowledge that I have read and understood all of the information contained within this document. Additionally, I acknowledge that all information that I have entered in this application, to the best of my knowledge, is complete, true, and accurate. I understand that any attempt to mislead or defraud AultCare is considered insurance fraud.

**INSURANCE FRAUD WARNING:** Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I acknowledge that AultCare may use and disclose my protected health information, as well as, the protected health information of my family for payment, treatment, and operations. This information may be disclosed to other insurance companies, third party administrators, state and federal agencies, health care providers and other organizations and persons that perform professional, business, or insurance functions for AultCare, as permitted by state and federal law.

The information may be used for, but not limited to, processing enrollment applications, risk classifications, detecting or preventing fraud, internal and external audits, claims administration, case management, quality improvement programs, public health reporting, law enforcement investigations, coordination of benefits, medical management programs, and subrogation.

**All Employees**

I have read all of the statements contained in this application and declare that by signing this application the information I have provided is true and complete to the best of my knowledge. Electronic Signature Disclaimer: Please be advised that AultCare will not deny the enforceability or effect of an electronic signature solely because it is in an electronic format. Any valid signature provided in this section shall have the same legal effect and enforceability as a manually executed signature. I authorize deduction from my wages, as necessary, for any required premium for the coverage for which I have applied.

Signature _____ _____

Date

**Employees Waiving Coverage**

I have read all of the statements contained in this application and declare by signing that the information I have provided is true and complete to the best of my knowledge. I understand that I am eligible to apply for coverage through my employer. And I acknowledge that, subject to the terms and conditions of the policy, by waiving coverage at this time, I may not be able to enroll myself or my family again until the next annual enrollment period or a special enrollment period. I hereby decline coverage for (check all that apply): ☐ Myself ☐ Spouse ☐ Child(ren)

Reason for waiver of coverage: _____

Signature _____ Spouse Signature _____ _____

Date

Per the 2015 FTC TCPA, AultCare or a vendor of AultCare, may contact you for demographic, satisfaction, and/or medical care management information in accordance with its obligation under Federal Law.

Date

**Please submit this form to AultCare by one of the following methods:**

Email: aultcareeligibility@aultcare.com | Fax: 330-363-7746 | Mail: AultCare Member Services PO Box 6910 Canton, OH 44706

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# *Cancellation/Continuation Notification*

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| | |
|---|---|
| **Today's Date:** | **Employer:** |
| **Group Numbers:** | **Completed By:** |

| EFFECTIVE DATE OF TRANSACTION | EMPLOYEE NAME LAST, FIRST, M. | ID NUMBER | TRANS. CODE | COVERAGE TYPE M-Medical, D-Dental, V-Vision | COMMENTS |
|---|---|---|---|---|---|
| | | | | | |
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| | | | | | |

Please indicate all cancellations on this report. Do not make changes on the monthly premium statement. Utilize transaction codes for each change. Include enrollment form where indicated and provide within 31 days of event. ***Signed enrollment forms must include spouse's signature when applicable.**

## TRANSACTION CODES

**Cancellation of Coverage:**

A. Cancellation – Left Employment/Termination (Include in Comments section Termination Date & if Voluntary, Involuntary or due to Gross Misconduct)

B. Cancellation – Deceased (Specify Date of Death in Comments section)

C. Cancellation – Layoff (Include in Comments section the Date of Layoff & if Voluntary or Involuntary)

D. Cancellation - Waiving (Specify in Comments if waiving coverage, include Enrollment Form with waiver section signed*.)

E. Cancellation – Reduction in hours: no longer meets minimum eligibility requirements

**Continuation of Coverage:**

F. COBRA Coverage Elected (Include Expiration Date, Copy of signed election form & proof of first payment) *(This is not necessary if AultCare administers the COBRA)*

G. State Continuation of Coverage (For employers under 20 – please indicate expiration date of State Continuation of Coverage in the Comments section. Please include a signed Continuation of Coverage Election Form.)

**Other**:

H. Other (Include detailed explanation)

I understand AultCare is relying on my answers to the above questions to ensure overall compliance for my group health plan. I certify the answers are true to the best of my knowledge and belief. I also understand I am responsible for promptly notifying AultCare if any information changes.

**Please submit this form to AultCare by one of the following methods:**
Email: aultcareeligibility@aultcare.com | Fax: 330-363-7746 | Mail: AultCare Member Services PO Box 6910 Canton, OH 44706

Please contact Customer Service with any questions: 330-363-6360

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# 5 | *Open Enrollment FAQ*

**Q. What is the expected timeline for a client/employer to submit open enrollment changes once the open enrollment period has ended?**

**A.** Submit open enrollment (OE) changes as soon as possible, but no later than 10 business days of the close of your OE period. Delays in OE submission will result in delays in member ID cards and coverage being in effect for prescription fills, as well as denied claims and incorrect monthly invoices. If this timeline is unattainable, contact your account coordinator or eligibility representative to establish an appropriate date for the submission of your OE changes.

**Q. Can we send our OE changes in a different format than our standard process?**

**A.** If you plan to send your OE in a format that you do not use currently, it is advisable to discuss this with your account coordinator to obtain approval before proceeding. Sending OE in a format that is not your standard could delay processing, which will cause delays in getting ID cards to employees.

**Q. We are adding an ancillary product, i.e., dental, vision, life, etc. to our benefit package. How can we send enrollment to AultCare?**

**A.** An enrollment election, within your standard enrollment process, is required to enroll the appropriate members into the new ancillary product.

**Q. What is the expected time frame for our members to obtain ID cards?**

**A.** Typically, it takes 7-10 business days for a member to receive their ID card once they are loaded into our system. At year end, enrollment must be delivered no later than the first Friday in December to guarantee ID card delivery by Jan. 1; otherwise, ID cards may be delayed.

Reminder: Members can view their ID cards on the website and mobile app once they have created a login.

**Q. Will all members receive new ID cards?**

**A.** No, cards will only be issued to members on plans that have made benefit changes, i.e.: copayment, deductible, out of pocket.

**Q. If we currently send paper applications for enrollment changes, is it necessary to send an application on every employee during open enrollment?**

**A.** No. If the Employee is not making plan election changes, adding or removing dependents/spouse, and/or does not have a demographic change, i.e. address change, then there is no need to complete and submit an enrollment application. Their current coverage will continue with no changes.

**Q. Our current enrollment vendor has questions relating to the open enrollment process. Who should they contact?**

**A.** Please reach out to your eligibility representative or account coordinator for additional information.

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## Notice of HIPAA Special Enrollment Rights

We would like to take this opportunity to advise you of an important provision in your health care plan. To participate, you must complete an enrollment form. Dependent upon which specific plan you wish to enroll in, you may have to pay part of the premium through payroll deduction.

Additionally, HIPAA requires that we notify you of the "Special Enrollment Provision".

### Special Enrollment Provision

**Loss of Other Coverage.** If you decline enrollment for yourself or for another eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within **30** days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

**New Dependent by Marriage, Birth, Adoption, or Placement for Adoption.** In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within **30** days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact your AultCare Service Center at 330-363-6360 or 1-800-344-8858.

### Procedures for Requesting Certificate of Creditable Coverage/Certificate of Health Plan Coverage

HIPAA requires that plan sponsors and/or insurers provide a Certificate of Creditable Coverage/Certificate of Health Plan Coverage (HIPAA Certificate) to each individual who requests one, so long as it is requested while the individual is covered under the AultCare Health Plan or within 24 months of the individual's coverage under the AultCare Health Plan ending. The request also can be made by someone else's behalf for an individual. For example, an individual who previously was covered under the AultCare Health Plan may authorize a new plan in which the individual enrolls to request a certificate of the individual's Creditable Coverage/Health Plan Coverage from the AultCare Health Plan. An individual is entitled to receive a Certificate upon request even if the AultCare Health Plan has previously issued a Certificate to that individual.

Requests for Certificates should be directed to AultCare Corporation, Attn: Member Services, P.O. Box 6910, Canton, Ohio 44706-0910 or by calling your AultCare Service Center at 330-363-6360 or 1-800-344-8858.

Telephone requests are accepted only if the Certificate is to be mailed to the address the plan has on file for the individual to who the request relates. Other requests must be made in writing.

All requests must include:

- The name of the individual for whom the Certificate is requested;
- AultCare Group Number and Identification Number

- The last date that the individual was covered under the plan;
- The name of the participant that enrolled the individual in the plan; and
- A telephone number to reach the individual for whom the Certificate is requested.

Required written request must also include:

- The name of the person making the request and evidence of the person's authority to request and receive the Certificate on behalf of the individual
- The address to which the Certificate should be mailed.
- The requester's signature

After receiving a request that meets these requirements, the plan will act in a reasonable and prompt fashion to provide the Certificate.

**(Note: A preexisting condition exclusion does not apply to enrollees of AultCare plans that have renewed effective January 1, 2014 and after.)**

**The Certificate of Creditable Coverage/Health Plan Coverage can be used as proof of loss of coverage.**

# AultCare/Aultra Insurance Plans—Notice of Privacy Practices
# Your Information. Your Rights. Our Responsibilities.

This Notice of Privacy Practices (NPP) describes how medical and claims information about you may be used and disclosed, how you can get access to your information, and your rights under HIPAA. **Please review this NPP carefully. Feel free to share it with your family or personal representative.**

## Introduction

AultCare Insurance Company (*dba* AultCare HMO), which is part of an Organized Health Care Arrangement with AultCare Corporation, AultCare Health Insuring Corporation dba PrimeTime Health Plan, and Aultra Administrative Group (AultCare or We) is a Group Health Plan Covered Entity under HIPAA.

We're committed to safeguarding the Privacy and Security of Protected Health Information of its enrollees and their eligible dependents (you) in paper (PHI) or electronic form (ePHI).

This NPP describes our HIPAA-compliant policies and procedures for the Use and Disclosure of your PHI/ePHI, including the use of PHI/ePHI for eligibility, enrollment, underwriting, claims processing, coordination of benefits, and payment of treatment under your group health plan in compliance with HIPAA's Privacy and Security Rules (updated by the Omnibus Rule of 2013), the HITECH Act, and the Genetic Information Nondiscrimination Act (GINA).

You may access this NPP on our website **www.aultcare.com**. If you do not have a computer or internet access, or if you want a paper copy of this NPP, please call our Service Center at **330-363-6361 or 1-800-344-8858.**

Not every use or disclosure of PHI, with or without a signed Authorization, is listed in this NPP. Uses or disclosures not specified in this NPP often require an Authorization. Please contact our Privacy Officer if you have a question, concern, or need further guidance.

## Terms

**Accounting**. An Accounting is a list of disclosures of your PHI/ePHI we have made.

**Authorization.** An Authorization is a document signed and dated by the individual who authorizes the use or disclosure of PHI/ePHI for purposes other than treatment, payment, or healthcare operations.

**Business Associates.** We contract with outside business associates that may access, use, or disclose PHI/ePHI to perform covered services for us. Examples include auditing, accounting, accreditation, actuarial services, and legal services. Business associates must protect the privacy and security of your PHI/ePHI to the same extent we do. If a business associate delegates services to a subcontractor or agent, that subcontractor or agent also is a business associate that must comply with HIPAA.

**Covered Entities.** Covered entities include health care providers (*e.g.* hospitals, doctors, nurses, nursing homes, home health agencies, durable medical equipment suppliers, other health care professionals and suppliers), and group health plans. AultCare is a group health plan covered entity.

**Designated Record Set.** A designated record set is a group of records containing PHI in paper or electronic form that we created and store. A designated record set includes medical, healthcare and service records, billing, claims and payment information, eligibility and enrollment information, and other information we use to make decisions regarding the coverage and payment of medical care under your plan. Records created by others are not part of a designated

record set.

**Disclose**. Disclose means our releasing, transferring, providing access to, or divulging PHI/ePHI to a third party, including covered entities and their business associates: (1) for treatment, payment, and health care operations; or (2) when you permit us by your signed authorization; or (3) as required by law.

**Genetic Information**. Genetic information includes genetic testing of the individual or family members.

**Health Plan**. Health plan means an individual or group health plan that provides, or pays the cost of, medical care and includes a health insurance issuer, HMO, Part A or B of Medicare, Medicaid, voluntary prescription drug benefit program, issuer of Medicare supplemental policy, issuer or a long-term care policy, employee welfare benefit plan, plan for uniformed services, veterans' health care program, CHAMPUS, Indian health service program, federal employee health benefit program, Medicare Advantage plan, approved state child health plan, high risk pool, and any other individual or group health plans or combination that provides or pays for the cost of medical care. AultCare is a group health plan.

**Health Care Operations**. Health care operations include quality assurance, performance improvement, utilization review, accreditation, licensing, legal compliance, provider/supplier credentialing, peer review, business management, auditing, enrollment, underwriting, stop-loss/reinsurance, and other functions related to your health plan, as well as offering and providing preventive, wellness, case management, and related services.

**Individual.** Individual means the enrollee or eligible dependent (including minors) to whom PHI belongs. It also applies to your family member or personal representative acting on your behalf.

**Minimum Necessary**. We will limit the use or disclosure of your PHI/ePHI to the minimum needed to accomplish the intended purpose of the use, disclosure, or request.

**Payment**. Payment means the activities by a group health plan to obtain premiums or to determine or fulfill its responsibility for coverage and the provisions of benefits under your plan and includes eligibility or coverage determination, coordination of benefits, adjudication and subrogation of health benefit claims, billing, claims management, EOBs, health care data processing, reinsurance (including stop-loss and excess), determination of medical necessity, utilization review (including pre-certification and retrospective review), and related activities.

**Personal Representative**. Personal Representative means a person acting on behalf of the individual, including family, spouse, guardian, attorney-in-fact under a durable or general power of attorney, or friend assisting the individual with healthcare and payment decisions.

**Protected Health Information (PHI/ePHI)**. PHI/ePHI means individually identifiable medical and health information regarding your medical condition, treatment of your medical condition, and payment of your medical condition, and includes oral, written, and electronically generated and stored information. PHI/ePHI excludes de-identified information or health information regarding a person who has been deceased for more than 50 years.

**Treatment**. Treatment means the provision, coordination, and management of health care and services by one or more health care providers, including referrals and consultations between providers or suppliers.

**Use**. Use means our accessing, sharing, employing, applying, utilizing, examining, or analyzing your PHI/ePHI within the AultCare organization for payment and health care operation purposes. Your PHI/ePHI is accessible only to members of AultCare's workforce who have been trained in HIPAA Privacy and have signed a confidentiality agreement that limits their access and use of PHI/ePHI, according to the minimum necessary standard, to perform the authorized

purpose.

**Wellness Program.** Wellness Program means a program that an employer has adopted to promote health and disease prevention, which is offered to employees as part of an employer-sponsored group health plan or separately as a benefit of employment.

## Your Rights

**When it comes to your health information, you have certain rights. This section explains some of your rights and our responsibilities.**

**You may have additional privacy rights:**

- You may have additional privacy rights under other applicable laws, including state law and Part 2 of Title 42 of the Code of Federal Regulations (as applicable to certain substance use disorder records). An applicable law that provides for greater privacy protection or privacy rights will continue to apply.

**You may get a copy or summary of your health and claims records:**

- You may ask to see or get a copy of your health and claims records and PHI kept in a designated record set. Please call the Service Center to ask how to do this. There are some restrictions.
- We will get you a paper copy or electronic version of your health and claims records, or give you a summary, usually within 30 days of your request. We may charge reasonable, cost-based fees.

**You may ask us to correct your health and claims records:**

- You may ask us in writing to correct your health and claims records in a designated records set if you believe they are incorrect, inaccurate, or incomplete. Please call the Service Center or visit our website to get an amendment request form.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- You will have an opportunity to appeal.

**You may request confidential communications of communications by alternative means:**

- You may ask us to contact you about claims, premiums, EOBs, or other matters about your health plan and coverage in a specific way, such as home phone, office phone, or cell phone, or by alternate means, such as an address different from your home or usual email address.
- Let us know if you do not want us to leave any voice mail message.
- Contact the Service Center to request. We will consider all reasonable requests.

**You may ask us to limit (restrict) what we use or disclose:**

- You may ask us in writing not to use or disclose certain health information for treatment, payment, or operations. We may honor your request if you pay for treatment in full out-of-pocket.
- Please call the Service Center for a restriction request form or visit our website.

- While we will consider reasonable requests, we are not required to agree to your request. We may say "no" if restricting information could affect your care or if disclosure is required by law.

**You may request a list ("Accounting") of those to whom we've disclosed PHI/ePHI:**

- You may ask in writing for a list of disclosures of your PHI/ePHI (Accounting) for the six years prior to your request.
- We will include all disclosures except for those about treatment, payment, and health care operations, and disclosures made to you or you authorized us to make. We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**You may get a copy of this NPP:**

- You may ask for a paper copy of this NPP at any time, even if you have agreed to receive this NPP electronically. We will provide you with a paper copy promptly. Members receive a copy of the Notice every 3 years, at the time of enrollment, and if there is a material change. You may access electronic copy of this NPP on our website at any time.

**You may choose someone to act for you:**

- You may choose a family member or personal representative to receive PHI/ePHI from us, exercise your rights, and make choices for you.
- We will use reasonable efforts to confirm that the person is authorized to act on your behalf before we take any action.

**You may file a complaint if you believe your rights have been violated:**

- If you believe your privacy or your HIPAA rights have been violated, we urge you to contact our privacy officer, either by calling the Service Center or filing a written complaint at AultCare, P.O. Box 6029, Canton, OH 44706.
- We take all complaints very seriously. We will investigate and take appropriate action if needed.
- You also may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting Complaint Process | HHS.gov.
- We will never retaliate against you for filing a complaint, asking a question, or expressing a concern.

## Communicating with You

**This section describes how we may communicate with you, family members, or your personal representative.**

**Communicating with You:**

- We may communicate with you about claims, premiums, or other things regarding your health plan.

**Communicating with Family or Others Involved In Your Care:**

- We may disclose your PHI/ePHI to designated family, friends, guardians, persons named in a durable or general power of attorney, personal representatives, or others assisting in your care or payment of claims.

**Minors and Emancipated Minors:**

- We may disclose a minor's PHI/ePHI to the minor's parent(s) or guardian, unless there are legal or policy reasons not to.

- We will not disclose PHI/ePHI to the parent(s) or guardian of an emancipated minor. A minor is emancipated if he/she: (1) does not live with his/her parent(s); (2) is not covered by parental health insurance; (3) is financially independent of parent(s); (4) is married; (5) has children; or (6) is in the military.

**Deceased Enrollees:**

- If you die, we may disclose your PHI to the executor or administrator of your estate.

- We may disclose PHI/ePHI to your spouse, family, personal representative, or others who were involved in your care or management of your affairs, unless doing so would be inconsistent with your wishes made known to us.

## Uses and Disclosures

**This section describes how we typically use or disclose your PHI/ePHI with and without an Authorization.**

**No Authorization Needed:**

- We will create, receive, or access your PHI/ePHI, which we may use or disclose to other covered entities for treatment, payment, and health care operations, without the need for you to sign an Authorization.

- We will disclose PHI/ePHI needed to treat or authorize treatment. For example, a doctor or health facility involved in your care may request your PHI/ePHI to make treatment decisions covered by the plan.
- We will use or disclose your PHI needed for payment. For example, we will use information about your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary, and to pre-authorize or certify services covered by your health plan.
- We may disclose PHI/ePHI to governmental or commercial health plans that may be obligated under coordination of benefit rules to process and pay your claims.
- We will use and disclose your PHI/ePHI as necessary or required by law to administer your plan and for our health care operations. For example, we may use or disclose PHI/ePHI for underwriting purposes. We will <u>not</u> use or disclose genetic information for underwriting purposes.
- We may disclose PHI/ePHI to business associates to perform covered services. It is not necessary for you to sign an Authorization for us to share PHI/ePHI with our business associates for covered services.
- We will use PHI/ePHI gathered from our online enrollment tools to complete certain applications for enrollment. The use of these tools is voluntary and alternate methods of enrollment may be available should you choose not to provide all of the requested information needed to complete the online enrollment.
- If we suspect child abuse or neglect, or if we think you are a victim of abuse, neglect or domestic violence.
- We may disclose an individual's PHI without authorization in a judicial or administrative proceeding if the request for the information is through an order from a court or administrative tribunal.

- We may disclose PHI to coroners and funeral directors consistent with the law.

**Authorization Needed:**

We will not use or disclose your PHI/ePHI for any purpose other than treatment, payment, or healthcare operations without your signed HIPAA-compliant Authorization, unless required by law.

- We will not disclose psychotherapy notes without a signed Authorization unless required by law.
- We will not disclose Substance Use Disorder Records in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or the use or disclosure is based on a court order and you or the holder of the record is provided notice and an opportunity to be heard, as provided in Part 2 of Title 42 of the Code of Federal Regulations. A court order authorizing use and disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.
- We will not disclose your PHI/ePHI to your employer without your signed Authorization. We may disclose PHI/ePHI to the plan sponsor of your health benefit plan on condition that the plan sponsor certifies that it will maintain the confidentiality of PHI/ePHI and will not use PHI to make employment-related decisions or employee benefit determinations.
- We will not release medical records if subpoenaed, unless you sign an Authorization, or the lawyers sign a qualified protective order, or if we receive a valid court or administrative order.
- We will not sell any of your health information without your authorization unless for treatment or payment purposes or as required by law.

**You may choose to receive information about health-related products or services or fundraising:**

- We may use your PHI/ePHI if we believe you may be interested in, or benefit from, treatment alternatives, wellness, preventive, disease management, or health-related programs, products or services that may be available to you as an enrollee or eligible beneficiary under your health plan. For example, we may use your PHI/ePHI to identify whether you have a particular illness and contact you to let you know about a disease management program is available to help manage your illness.
- Let us know if you do not want to be contacted or receive information about these services and programs. Opting out will not affect coverage or services.
- We will not sell or disclose your PHI/ePHI to third parties for marketing without your Authorization, which will indicate whether we are paid for selling PHI.
- We may contact you about charitable fundraising. If you do not want to be contacted or receive fundraising materials, let our Service Center know. Opting out will not affect coverage or services.

**Wellness Programs:**

- If you voluntarily choose to participate in a Wellness Program, you may be asked to answer questions on a health risk assessment (HRA) and/or undergo biometric screenings for risk factors,
- Wellness Programs may also provide educational health-related information or services that may include nutrition classes, weight loss and smoking cessation programs, onsite exercise facilities, and/or health coaching to help employees meet their health goals.
- If your employer has entered or may enter into a contract with us to perform services, as well as receive, collect, use, disclose, and store data in connection with a Wellness Program. We will protect the privacy of your PHI.

## Use and Disclosure of Health Information Permitted or Required by Law

**We may use or disclose PHI/ePHI, without your Authorization, as required by law, including, but not limited to:**

- Workers' Compensation
- Public health agencies
- FDA and OSHA
- Ohio Department of Insurance and other regulatory and licensing agencies
- Armed Forces to assist in notifying family members of your location, general condition, or death
- Law Enforcement
- Homeland security
- Emergency and disaster
- Prevent threat of serious harm
- Proof of immunization
- Opportunity to Agree or Object
- Public Interest and Benefit Activities
- Limited Data Set for the purposes of research, public health or health care operations.

## Breach Notification

- You have the right to notification within 60 calendar days after discovery of a breach if a breach of your PHI/ePHI occurs. We will promptly notify you by first-class mail, at your last known address, or by email (if you prefer) if we discover a breach of unsecured PHI/ePHI, which includes the unauthorized acquisition, access, use, or disclosure of your PHI/ePHI, unless we determine through a risk analysis that a low probability exists that the compromise of your PHI would cause you financial, reputational, or other harm.

- We will include in the breach notification a brief description of what happened, a description of the types of unsecured PHI involved, steps you should take to protect yourself from potential harm, a brief description of what we are doing to investigate the breach and mitigate any potential harm, as well as contact information for you to ask questions and learn additional information.

## Changes to this NPP

**This section describes how and when we make changes and how we will inform you of any material changes.**

- We reserve the right to change this NPP at any time, which we may make effective for PHI/ePHI we already used or disclosed, and for any PHI/ePHI we may create, receive, use, or disclose in the future.
- We will make material amendments based on changes in the HIPAA laws.
- The revised NPP will be posted on our website www.aultcare.com. Copies of revised NPPs will be mailed to all enrollees covered by the plan, and copies may be obtained by mailing a request to: Privacy Coordinator, P.O. Box 6029, Canton, Ohio 44706.

**If you have questions or need further assistance regarding this NPP, you may contact the Service Center at 330-363-6360 or 1-800-344-8858. If you are hearing impaired and have access to a TTY phone, you may reach us at our TTY line at 711. Our Service Center hours are from 7:30 a.m. to 5:00 p.m., Monday-Friday.**

Review Date: 2/5/2026
Effective Date: 2/11/2026

## AultCare/Aultra General Tag Lines for the State of Ohio

**English**
If you, or someone you are helping, have questions about **AultCare/Aultra** you have the right to get help and information in your language at no cost. To speak with an interpreter, call **Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 711 Outside Stark County: 711**

**Spanish**
Español
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca **AultCare/Aultra** tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 711 Fuera del condado de Stark : 711**

**Chinese**
中文
如果您，或是您正在協助的對象，有關於**AultCare/Aultra保險公司** 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 本地： **330.363.6360 斯塔克縣外： 1.800.344.8858 TTY線本地： 711斯塔克縣外： 711**。

**German**
Deutsche
Falls Sie oder jemand, dem Sie helfen, Fragen zum **AultCare/Aultra** haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County : 711** an.

**Arabic**
العربية
العربية، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب AultCare/Aultra إن كان لديك أو لدى شخص تساعده أسئلة بخصوص شركة التأمين
خارج مقاطعة ستارك . 711 المحلي: 711 الخط **TTY** خارج مقاطعة ستارك : 330.363.6360 1.800.344.8858

**Pennsylvania Dutch**
Deitsch

Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut **AultCare/Aultra** hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du **Local: 330.363.6360 Außerhalb von Stark County: 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County : 711** uffrufe.

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**Russian**
русский
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу **Страховая компания AultCare/Aultra**, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 711 Вне Старка County : 711.**

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**French**
Français
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de **Compagnie d'Assurance AultCare/Aultra**, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, **Appelez Locale 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 711 En dehors du comté de Stark : 711**.

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**Vietnamese**
Việt Nam
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về **Công ty Bảo hiểm AultCare/Aultra** quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 711 Bên ngoài của Stark County : 711.**

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**Cushite-Oromo**
Isin yookan namni biraa isin deeggartan **AultCare/Aultra,** irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 711 Outside of Stark County: 711** tiin bilbilaa.

**Korean**
한국어
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이**AultCare/Aultra 보험 회사** 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 711 스타크 카운티 의 외부 : 711**
로 전화하십시오.

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**Italian**
Italiano
Se tu o qualcuno che stai aiutando avete domande su **AultCare/Aultra**, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 711 Al di fuori di Stark County : 711.**

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**Japanese**
日本語
ご本人様、またはお客様の身の回りの方でも**AultCare/Aultra**保険会社についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、

ローカル： **330.363.6360 スターク郡の外： 1.800.344.8858 TTYライン ローカル： 711 スターク郡の外： 711までお電話ください。**

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**Dutch**
Nederlands
Als u, of iemand die u helpt, vragen heeft over **AultCare/Aultra,** heeft u het recht om hulp en informatie te krijgen in uw taal zonder kosten. Om te praten met een tolk, bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 711 Buiten Stark County : 711.**

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**Ukrainian**
український
Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про **Страхова компанія AultCare/Aultra,** у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на
**Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 711 Поза Старка County : 711.**

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**Romanian**
Română
Dacă dumneavoastră sau persoana pe care o asistați aveți întrebări privind **Compania de Asigurari AultCare/Aultra**, aveți dreptul de a obține gratuit ajutor și informații în limba dumneavoastră. Pentru a vorbi cu un interpret, sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 711 In afara Stark Judet : 711.**

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**Non-Discrimination Notice:**

AultCare/Aultra complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)) AultCare/Aultra does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

AultCare/Aultra:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact CivilRightsCoordinator@aultcare.com.

If you believe that AultCare/Aultra 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: CivilRightsCoordinator@aultcare.com. 2600 6th St. S.W. Canton, OH 44710, 330-363-7456, TTY number- 711. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, CivilRightsCoordinator@aultcare.com 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, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

# 7 | *Employer Group Size Information*

**Various state and federal laws have requirements based on employee counts in determining how each regulatory guideline applies to an employer-sponsored health plan, including the Patient Protection and Affordable Care Act (ACA), COBRA, State Continuation, Medicare Secondary Payor, etc. Each year, AultCare will request employers to complete the Annual Determination of Group Size Demographics form, to assist employers with this responsibility. When counting employees, it's important to conduct a related employer analysis.**

- Annual Group Size Demographics:
  - > Employers with 20 or more employees on at least half of the working days during the previous calendar year are required to offer COBRA.
- Medicare Coordination - Working Age Employees:
  - > Medicare coordination rules for working age employees are based on the employer size to determine whether the Employer plan or Medicare is primary.

**For details, please visit AultCare.com/employer-forms and scroll down to the Miscellaneous tab.**

**Look for both the AultCare Employee Count Analysis and AultCare Group Size Demographic Form links.**

*Ohio's Statutory Requirements*

# 8 | *Continuation of Employee Health Care Coverage*

COBRA vs State Continuation:

- Employers with 20 or more employees on at least half of the working days during the previous calendar year are required to offer COBRA.
- Employer to determine COBRA administrator.
- Employers with fewer than 20 employees must offer state continuation for involuntary terminations, other than gross misconduct.
- Employer to administer.

AULTCARE

## *Ohio's Statutory Requirements*

# *Continuation of Employee Health Care Coverage*

**Ohio's law provides that an employee has a right to continue coverage under his or her employer's group health plan upon involuntary termination of employment if certain requirements are met. All employer groups should be knowledgeable about Ohio's continuation insurance laws; employers with fewer than 20 employees must be particularly aware of the requirements. For those employers, Ohio's continuation coverage is the only continuation coverage available to their employees.**

### An employee is eligible for continuation of coverage if he or she satisfies all of the following requirements:

- Employee must have been continuously covered under the employer's group health plan during the entire three months preceding his or her termination.
- Employee must have been involuntarily terminated for reasons other than gross misconduct.
- Employee is not eligible for or enrolled in Medicare or other group health coverage or COBRA.

### If an employee satisfies these requirements, then the employer must offer that employee the right to continue coverage under its group health plan (even after the employee loses eligibility as a member of that group). The employer must inform the employee of his or her contribution amount in advance.

### Important Notes:

- Coverage is only available for a maximum of 12 months.
- Coverage is not required to include benefits in addition to the hospital, surgical or major medical coverage, and prescription drug coverage if covered under the group policy. However, it may include dental, vision or other benefits under the health plan.
- Payment is due from the employee to the employer in advance of each month of continuation coverage.
- Continuation coverage ceases if the employee fails to make timely premium payments. There is no grace period.
- Coverage ceases if the employee becomes eligible for or is covered under Medicare or any other group health plan.

This information is only intended to highlight the major requirements for the right to receive continuation of coverage and is not intended to offer legal guidance or advice regarding how an employer can comply with Ohio's laws. There are many other significant requirements relating to continuation insurance not covered in this notice.

Employers are advised to consult with their tax professionals and attorneys to ensure compliance with these state laws. Employers may also call the Ohio Department of Insurance at 614-644-2658 or visit *www.insurance.ohio.gov* for additional information.

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# Ohio State Continuation Guidelines

| Qualifying Event | Eligibility Requirement (Must Meet All) | Eligible Beneficiary | Maximum Coverage Time | Notice Requirements | Election | Coverage Ceases When |
|---|---|---|---|---|---|---|
| **Termination of Employment** | 1) Covered by group health plan at least three months prior to termination; | Employee<br>Spouse<br>Dependent Child(ren) | 12 Months | 1) Employer must notify Employee of right of continuation at time Employee is notified of termination | Employee must request continuation coverage and pay the first contribution to the Employer by the earliest of the following dates: | 1) Premium payments are not made on a timely basis. NOTE: Payment can be made by parties other than the Employee. |
| | 2) Involuntary termination other than gross misconduct | | | 2) Employer must notify Insurer of Employee's continuation of coverage. | 1) 31 days after date Employee's coverage terminates | 2) Group policy is terminated by the Employer. |
| | | | | | 2) 10 days after date Employee's coverage terminates, if Employer has notified Employee of right to continuation prior to that date | 3) Period of 12 months expires after date Employee's coverage would have terminated because of termination of employment. |
| | 3) Not eligible for or enrolled in Medicare or other group health coverage. | | | | 3) 10 days after date Employer notifies Employee of right to continuation if notice is given after Employee's coverage terminates | 4) Employee becomes eligible for or covered by Medicare or any group health plan. |
| **Reservist called or ordered to active duty** | 1) Employee is a reservist called or ordered to active duty;<br>**and**<br>2) Policy in effect covers eligible person at time of active duty. | Employee<br>Spouse<br>Dependent Child(ren) | 18 months after date coverage would otherwise terminate with an option to extend to 36 months. | At the time reservist is called to duty, Employer notifies Employee about continuation. | Eligible person files a written election of continuation with the Employer and pays the first required contribution no later than 31 days after the date on which the coverage would otherwise terminate. | 1) Premium payments are not made on a timely basis. NOTE: Payment may be made by parties other than the enrollee.<br>2) Group policy is terminated by the Employer. |

# 9 | *Monthly Invoices*

An example of the monthly invoice that each client receives is provided on the following page. The invoice you receive may differ in column headings and amounts.

Examples of column headings include: Medical, Dental, Vision, various PPO Access Fees, COBRA and HIPAA. The last column provides the total fees for each employee.

- The top portion of the invoice indicates the run date of the invoice and the due date of the payment. AultCare strives to have all invoices run by the 15th of each month and posted to the AultCare website, AultCare.com. Payment is then due by the date indicated. You will be notified by email when the invoices are available on your account.

Any adjustments made to enrollments, such as new additions or terminations, will be indicated in a section before the grand total. Eligibility changes that were received by the 10th of the month will be reflected on that month's bill.

- It is your responsibility to review this monthly billing for accuracy.
- Please note: Payments must equal the grand total billed. Do not take adjustments to the amount due. Necessary adjustments due to enrollment changes will be made on next month's invoice.
- Retrospective terminations will only be credited up to three months.

Please remit premium payment by:

- Electronic payments may be made to AultCare via ACH Transfer or AultCare may draft from your account. To update your payment options, please contact your AultCare account management team for assistance.

AULTCARE

# *Invoice Statement Glossary of Terms*

- **Account Summary Statement** – The new billing statement will be referred to as an Account Summary Statement. You may have more than one account summary because our claims management system billing module organizes account statements by product, which could include different plan or benefit types.
- **Companion Spreadsheet** – To provide improved analytic capabilities, we have created a companion spreadsheet, which conveniently combines multiple account summary statements. The spreadsheet contains multiple worksheets with different breakouts of your billing statement including Detail, Summary of Coverage Type, Summary by Rate Code and Summary by Invoice Number. (Click on the Sample Excel Invoice link under the Miscellaneous category to open the document.) The companion spreadsheet can be accessed through our secure AultCare Employer Web Portal. If you do not have an online account, please refer to Section 2 of the Administration Manual.
- **Additional Columns** – On the third page of the sample billing statement, you will find additional columns. Our new billing statement is a universal bill, and many of our clients have multiple products, which are reflected in the columns.
- **Statement Date** – Typically, AultCare runs your bill 15 days prior to the due date. Payments submitted for a prior month that do not arrive by the statement date may not appear on your next month's bill.
- **Rate Code** – The rate code reflects how we categorize your employee population. Rate codes can reflect coverage type, plan type and other internal classifications required to accurately administer your plan.
- **Payment Methods** – You may send one check, even though you may have received multiple account summary statements. It is important to note that you must return all remittance vouchers at the bottom of each account summary statement to ensure proper posting. The total due can be found on the detail page under the Grand Total heading. Complete the funding form with your desired payment method.
  - **Payment by EFT** – *Paying by EFT is the easiest and quickest way to pay your bill.*
  - **Payment by Check** – You may pay by check, but please remember to *return all remittance vouchers to ensure proper posting.*

# ACCOUNT SUMMARY STATEMENT

The Account Summary Statement is the name of your new bill(s).

AULTCARE

| | |
|---|---|
| **Company:** | GROUP NAME — Your group name will appear here. |
| **Group Number:** | GROUP01 — Your group number will appear here. |
| **Invoice Number:** | ARIU00000000001 — Each Account Summary Statement will have a unique Invoice Number. |
| **Billing Period:** | 08/2018 |
| **Due Date:** | 08/01/2018 |

**Statement Date: 07/15/2018** The Statement Date is 15 days prior to the payment due.

## ACCOUNT SUMMARY

| | |
|---|---|
| Previous Account Balance | $7,182.40 |
| *Adjustment Total* | $0.00 |
| *Current Charge* | $2,191.25 |
| **Total Amount Due** | **$9,373.65** |

## FOR CORRESPONDENCE

Please feel free to contact us by phone, or mail.
**Phone:** 330.363.6360 / **TOLL FREE:** 1.800.344.8858
**TTY Line:** 330.363.2393 / **TOLL FREE:** 1.866.633.4752
**Service Hours:** Mon-Fri 7:30am to 5:00pm
**Website:** www.aultcare.com

## PLEASE SEND ALL OTHER CORRESPONDENCE TO:

PO BOX 6910
CANTON OH 44706-0910

## MESSAGES

***Thank you for choosing AultCare.***

Please include coupon below with your monthly premium payment.

Enrollment changes must be submitted on the proper form to our Member Services department by the 10th of each month to appear on the next billing cycle.

Electronic Funds Transfer is available for automatically funding your monthly invoice. If you choose this easy option, premiums will be drafted out of your account on a monthly basis on the due date.

**Our mailing address for payments has changed. Please notify your bank if you pay using online banking.**

*Return the portion below with your payment to AultCare.*
*Thank you for your business.*

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AULTCARE

AULTCARE INSURANCE COMPANY
PO BOX 6910
CANTON OH 44706-0910

This bottom portion of your Account Summary Statement is the Remittance Voucher. Every Remittance Voucher must be returned with your bill.

**ACCOUNT NUMBER:** AAIP00000000001

**DUE DATE:** 08/01/2018

**TOTAL AMOUNT DUE: $9,373.65**

134680-AULTCARE-1

Please Remit Payment to:

GROUP NAME
123 S MAIN ST
CANTON OH 44720-3021

AULTCARE INSURANCE COMPANY
PO BOX 94603
CLEVELAND OH 44101

AAIP000000000010080937365 7

# ACCOUNT SUMMARY STATEMENT

AULTCARE

| | |
|---|---|
| **Company:** | GROUP NAME |
| **Group Number:** | GROUP01 |
| **Invoice Number:** | ARIU00000000002 |
| **Billing Period:** | 08/2018 |
| **Due Date:** | 08/01/2018 |

**Statement Date: 07/15/2018**

## ACCOUNT SUMMARY

| | |
|---|---|
| Previous Account Balance | $2,365.50 |
| *Adjustment Total* | -$373.10 |
| *Current Charge* | $709.65 |
| **Total Amount Due** | **$2,702.05** |

## FOR CORRESPONDENCE

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**TTY Line:** 330.363.2393 / **TOLL FREE:** 1.866.633.4752
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PO BOX 6910
CANTON OH 44706-0910

## MESSAGES

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Electronic Funds Transfer is available for automatically funding your monthly invoice. If you choose this easy option, premiums will be drafted out of your account on a monthly basis on the due date.

**Our mailing address for payments has changed. Please notify your bank if you pay using online banking.**

*Return the portion below with your payment to AultCare.*
*Thank you for your business.*

AULTCARE

AULTCARE INSURANCE COMPANY
PO BOX 6910
CANTON OH 44706-0910

**ACCOUNT NUMBER:** AAIP00000000002

**DUE DATE:** 08/01/2018

**TOTAL AMOUNT DUE: $2,702.05**

134680-AULTCARE-2

Please Remit Payment to:

GROUP NAME
123 S MAIN ST
CANTON OH 44720-3021

AULTCARE INSURANCE COMPANY
PO BOX 94603
CLEVELAND OH 44101

AAIP000000000020802702053

**GROUP NAME:** GROUP NAME

**GROUP NUMBER:** GROUP01

**PERIOD:** 08/2018

AULTCARE

| MEMBER NAME/ RATE CODE | COV TYPE | COBRA | LEASED NETWORK | PREMIUM/ ADMIN | NETWORK FEES | DENTAL | VISION | HRA/HSA/ FLEX | STOP LOSS | ANCILLARY | BROKER FEES | TOTAL FEES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **BALANCE FORWARD:** | | | | | | | | | | | | **$9,547.90** |
| **RATE CODE 1** | | | | | | | | | | | | |
| BROWN, JIM | 1 | | | 236.55 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $236.55 |
| DELAMIELLEURE, JOE | 1 | | | 236.55 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $236.55 |
| GRAHAM, OTTO | 1 | | | 236.55 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $236.55 |
| **RATE CODE 1 TOTAL** | | | | **709.65** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **$709.65** |
| **RATE CODE 2** | | | | | | | | | | | | |
| BROWN, PAUL | 1 | | | 427.70 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $427.70 |
| HICKERSON, GENE | 1 | | | 427.70 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $427.70 |
| LAVELLI, DANTE | 2 | | RN35 | 898.15 | 10.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $908.15 |
| MOTLEY, MARION | 1 | | | 427.70 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | $427.70 |
| **RATE CODE 2 TOTAL** | | | | **2181.25** | **10.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **$2,191.25** |
| **INVOICE TOTAL:** | | | | | | | | | | | | **$2,900.90** |
| **June 2018 Adjustments** | | | | | | | | | | | | |
| KOSAR, BERNIE | 1 | | | -236.55 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | -$236.55 |
| | | | | | | | | | | | | **-$236.55** |
| **July 2018 Adjustments** | | | | | | | | | | | | |
| KOSAR, BERNIE | 1 | | | -236.55 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | -$236.55 |
| | | | | | | | | | | | | **-$236.55** |
| **Manual Adjustments:** | | | | | | | | | | | | |
| COBRA PACKETS | | | | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 100.00 | 0.00 | $100.00 |
| | | | | | | | | | | | | **$100.00** |
| **Total Adjustments:** | | | | **-473.10** | **0.00** | **0.00** | **0.00** | **0.00** | **0.00** | **100.00** | **0.00** | **-$373.10** |
| **GRAND TOTAL:** | | | | | | | | | | | | **$12,075.70** |

**Coverage Type**

1 EMPLOYEE (INDIVIDUAL) ONLY
2 EMPLOYEE AND SPOUSE

**Leased Network Description**

RN35 PRIVATE HEALTHCARE SYSTEMS

**Coverage Counts**

| | |
|---|---|
| EMPLOYEE (INDIVIDUAL) ONLY | 6 |
| EMPLOYEE AND SPOUSE | 1 |

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Phone: 330.363.6360 • Toll Free: 1.800.344.8858 • TTY Line: 330.363.2393 1.866.633.4752

# *Insured Plans Monthly Premium Funding*

## Funding Arrangements
### ADMINISTRATIVE FEES

**COMPANY NAME:** _____ **GROUP #:** _____

**ADMINISTRATIVE FEE INVOICE – MONTHLY:**
**(***Pay as billed, enrollment adjustments will be made to subsequent invoices)*

**PAYMENT ARRANGEMENT -** Select and complete **ONE** option

ACH Payment **sent to** AultCare: ☐ Yes ☐ No

AultCare Account Information:
Account Number: 01039702501
Routing Code: 044000024

ACH Payment **pulled by** AultCare: ☐ Yes ☐ No

Your Account Information (*required*):
Bank Name: _____
Bank Contact & Phone Number: _____
Account Number: _____
Routing Code: _____
Tax ID: _____

***Note: Automatic withdrawal on the 1st of every month***

Completed by: _____ Signature: _____ Date: _____

Forward to aultcarebilling@aultcare.com.

# 10 | *Enrollee Questionnaires*

**Enrollees may receive questionnaires if additional information is needed. Encourage employees to respond to any forms received in order to have their claims paid quickly and correctly.**

### 1. Other Coverage Information Form (two-page form)

When other coverage information is needed, an Other Coverage Information form will be mailed to the employee for completion.

### 2. Accident Questionnaire

The Accident Questionnaire is mailed to a member to determine if an injury may be the responsibility of a third party. If a third party is at fault, AultCare will pursue reimbursement for the plan. Claims may be denied until the requested information is received.

### 3. Designation of Authorized Representative Form

The Designation of Authorized Representative Form is used to confirm permission to discuss with or disclose a person's protected health information (PHI).

### 4. Grievance and Appeal Information

The Grievance and Appeals process describes how a member or healthcare provider may submit a formal complaint or an appeal of a determination. There are two levels of appeals: internal and external. Refer to the website for the member and provider appeal forms.

**For examples of these and other member forms, please visit AultCare.com/member-forms.**

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## 11 | *Summary of Benefits and Coverage Guidelines (SBC)*

The SBC is a document provided annually by your health plan insurer that outlines your plans' key benefit features and coverage limitations.

**Employer Guide to SBCs** – As an employer you have an obligation to provide the SBC to eligible employees at specific times throughout the plan year, as specific events occur or at the member's request. Review the Employer Guide to ensure compliance with this requirement of the Affordable Care Act.

**The Glossary of Health Coverage & Medical Terms** – As an employer you have an obligation to also provide the glossary to eligible employees. The glossary provides commonly used health care terms and definitions.

For details, please visit AultCare.com/employer-forms and scroll down to the Guides tab. Click the link for AultCare Employer Guide (SBC).

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