

Explanation of Benefits and Appeals



Explanation of Benefits:

AultCare is now posting Explanation of Benefits (EOB) forms electronically. You can access, view or print an electronic EOB from the AultCare website anytime you want. Please refer to the following instructions.

Encourage your employees to obtain access to their claim information on the website or to call the service center to answer specific questions about their claims.

Appeals:

The attached documents outline AultCare's appeal procedures and timelines.

Internal Appeal Request Form –If you disagree with a determination decision about a specific benefit, you have the right to file an internal appeal with AultCare using this form. You may also submit your appeal in writing and include any comments, documentation or records relevant to your appeal.

AultCare Treating Physician Certification for Experimental/Investigational ABD- You may have your provider complete this form if your request for benefit determination has been denied as Experimental or Investigational. *(We do not require completion of this form, but provide it for your convenience. Your provider must certify to us in writing that your request is of an expedited nature before we will proceed with it as an expedited appeal.)*

AultCare Treating Physician Certification for Internal Appeal and/or External Review – You may have your provider complete this form if your request for benefit determination has been denied and you are requesting an expedited appeal or review. *(We do not require completion of this form, but provide it for your convenience. Your provider must certify to us in writing that your request is of an expedited nature before we will proceed with it as an expedited appeal.)*

External Review Request Form –If you disagree with our appeal decision and have exhausted your internal appeal rights, you can request an External Review using this form. *(For Insured and Public Employer Plans Only).*

AultCare Request for Review by the Ohio Department of Insurance –If we have denied your request for an External Review and you disagree with our decision, please use this form.

External Review Procedures Summary –An explanation of the External Review procedure for all Insured and Public Employer Plans effective 02/2012.



Dear Member,

It is important to us that you understand your benefits, as well as our operating procedures prior to your enrollment. This would include, but is not limited to, the following:

- Covered Benefits
- Non-Covered Benefits
- Access to doctors, health care providers, and facilities (Provider Network)
- Key medical management (utilization management) procedures
- Potential network, service, or benefit restrictions
- Pharmaceutical management procedures
- Policies and practices regarding collection, use, and disclosure of Protected Health Information (PHI), including:
 - Routine notification of privacy practices
 - Use of authorizations
 - Access to medical records
 - Protection of oral, written, and electronic information across the organization
 - Information for employers

To ensure this information is easily accessible to our potential members, we provide the information in our Member Guide, which is located on our website: www.aultcare.com. The Member Guide is located on the 'Member' page of the website.

To request a printed copy of the Member Guide, please contact our Customer Service Department at 330-363-6360 or 1-800-344-8858.

Customer service representatives are available weekdays from 7:30am – 5:00pm. (For hearing- impaired assistance, please call 330-363-2393 or 1-866-4752).



EXTERNAL REVIEW PROCEDURES SUMMARY

Understanding the External Review Process

Under Ohio law, AultCare is required to provide a process that allows a person covered under a health benefit plan or a person applying for health benefit plan coverage to request an independent external review of an adverse benefit determination. An adverse benefit determination is a decision by AultCare not to provide benefits because we believe services are not medically necessary, or not covered, excluded, or limited under the plan, or we believe the covered person is not eligible to receive the benefit. An adverse benefit determination can also be a decision to deny health benefit plan coverage or to rescind coverage.

Opportunity for External Review

An external review may be conducted by an Independent Review Organization (IRO) or by the Ohio Department of Insurance.

A covered person is entitled to an external review by an IRO in the following instances:

- The adverse benefit determination involves a medical judgment or is based on any medical information.
- The adverse benefit determination indicates the requested service is experimental or investigational, and the treating physician certifies at least one of the following:
 - » Standard healthcare services have not been effective in improving the condition of the covered person.
 - » Standard healthcare services are not medically appropriate for the covered person.
 - » No available standard healthcare service covered by AultCare is more beneficial than the requested healthcare service.

There are two types of IRO reviews, standard and expedited. A standard review is normally completed within 30 days. An expedited review for urgent medical situations is normally completed within 72 hours and can be requested if any of the following applies:

- The covered person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function if treatment is delayed until after the time frame of an expedited internal appeal or a standard external review.
- The adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare service for which the covered person received emergency services, but has not yet been discharged from a facility.
- An expedited internal appeal is in process for an adverse benefit determination of experimental or investigational treatment and the covered person's treating physician certifies in writing that the recommended healthcare service or treatment would be significantly less effective if not promptly initiated.

EXTERNAL REVIEW PROCEDURES SUMMARY

A covered person is entitled to an external review by the Ohio Department of Insurance in either of the following instances:

- The adverse benefit determination is based on a contractual issue that does not involve a medical judgment or any medical information.
- The adverse benefit determination indicates that emergency medical services did not meet the definition of emergency AND the health plan issuer's decision has already been upheld through an external review by an IRO.

Request for External Review

- The covered person must request an external review within 180 days of the date of the notice of final adverse benefit determination issued by AultCare.
- All requests must be in writing, except for a request for an expedited external review.
- Expedited external reviews may be requested electronically or orally; however, written confirmation of the request must be submitted to AultCare no later than five (5) days after the initial request.
- If the request is complete, AultCare will initiate the external review and notify the covered person in writing that the request is complete and eligible for external review.
 - » The notice will include the name and contact information for the assigned IRO or the Ohio Department of Insurance (as applicable) for the purpose of submitting additional information.
 - » The notice will inform the covered person that, within 10 business days after receipt of the notice, they may submit additional information in writing to the IRO or the Ohio Department of Insurance (as applicable) for consideration in the review.
- AultCare will also forward all documents and information used to make the adverse benefit determination to the assigned IRO or the Ohio Department of Insurance (as applicable).
- If the request is not complete, AultCare will inform the covered person in writing and specify what information is needed to make the request complete.
- If AultCare determines that the adverse benefit determination is not eligible for external review, we must notify the covered person in writing and provide the covered person with the reason for the denial and inform the covered person that the denial may be appealed to the Ohio Department of Insurance.
- The Ohio Department of Insurance may determine the request is eligible for external review regardless of the decision by AultCare and require that the request be referred for external review. The Department's decision will be made in accordance with the terms of the health benefit plan and all applicable provisions of the law.



EXTERNAL REVIEW PROCEDURES SUMMARY

IRO Assignment

- The Ohio Department of Insurance maintains a secure web based system that is used to manage and monitor the external review process.
- When AultCare initiates an external review by an IRO in this system, the Ohio Department of Insurance system randomly assigns the review to an Ohio accredited IRO that is qualified to conduct the review based on the type of healthcare service.
- AultCare and the IRO are automatically notified of the assignment.

IRO Review and Decision

- The IRO must forward, upon receipt, any additional information it receives from the covered person to AultCare. At any time, AultCare may reconsider its adverse benefit determination and provide coverage for the healthcare service. Reconsideration will not delay or terminate the external review. If AultCare reverses the adverse benefit determination, they must notify the covered person, the assigned IRO and the Ohio Department of Insurance within one day of the decision. Upon receipt of the notice of reversal by AultCare, the IRO will terminate the review.
- In addition to all documents and information considered by AultCare in making the adverse benefit determination, the IRO must consider things such as: the covered person's medical records, the attending healthcare professional's recommendation, consulting reports from appropriate healthcare professionals, the terms of coverage under the health benefit plan, and the most appropriate practice guidelines.
- The IRO will provide a written notice of its decision within 30 days of receipt by AultCare of a request for a standard review or within 72 hours of receipt by AultCare of a request for an expedited review. This notice will be sent to the covered person, AultCare and the Ohio Department of Insurance and must include the following information.
 - » A general description of the reason for the request for external review.
 - » The date the independent review organization was assigned by the Ohio Department of Insurance to conduct the external review.
 - » The dates over which the external review was conducted.
 - » The date on which the independent review organization's decision was made.
 - » The rationale for its decision.
 - » References to the evidence or documentation, including any evidence-based standards, that were used or considered in reaching its decision.



EXTERNAL REVIEW PROCEDURES SUMMARY

Binding Nature of External Review Decision

- An external review decision is binding on AultCare except to the extent that we have other remedies available under state law. The decision is also binding on the covered person except to the extent the covered person has other remedies available under applicable state or federal law.
- A covered person may not file a subsequent request for an external review involving the same adverse benefit determination that was previously reviewed unless new medical or scientific evidence is submitted to AultCare.

Please use the information below if you have questions about your rights or need assistance.

Ohio Department of Insurance

ATTN: Consumer Affairs

50 West Town Street, Suite 300, Columbus, OH 43215

800-686-1526 / 614-644-2658

614-644-3744 (fax)

614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Complaint.mvc/DisplayConsumerComplaintForm>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>



EXTERNAL REVIEW REQUEST FORM

Name of person filing request for external review _____

Relationship to covered person ☐ Covered Person/Applicant

☐ Authorized Representative (*please complete the Appointment of Authorized Representative section*)

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

COVERED PERSON/APPLICANT INFORMATION

Name		ID Number	
Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION

Name		Phone Number	
Mailing Address	City	State	Zip code
Email Address		Fax Number	
Contact Person		Phone Number	

External Review Specifications

1. If your situation is urgent, are you requesting an expedited review?* ☐ Yes ☐ No

*If you answer yes, your physician must certify your condition could, in the absence of immediate medical treatment, result in the following:

- Seriously jeopardize your life or health or your ability to regain maximum function, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

2. Is your requested healthcare service considered an experimental or investigational treatment? ** ☐ Yes ☐ No

**If you answer yes, your physician must certify that they are requesting authorization for a drug, device, procedure, or therapy denied for coverage due to the determination that the treatment is experimental and/or investigational and your medical condition meets certain requirements:

- Standard healthcare services have not been effective in improving your condition.
- Standard healthcare services are not medically appropriate for you.
- There is no available standard healthcare service covered by the health plan issuer that is more beneficial than the requested healthcare service.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize to pursue my external review on my behalf.

Signature of Covered Person (or legal representative*)

Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records. I hereby request an external review. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider and/or health plan issuer to release all relevant medical or treatment records to the Independent Review Organization and/or the Ohio Department of Insurance. I understand that the Independent Review Organization and the Ohio Department of Insurance will use this information to make a determination on my external review and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

Signature of Covered Person (or legal representative*)

Date

**Parent, Guardian, Conservator or Other - please specify*

Send this form and a copy of your notice of final adverse benefit determination to one of the following:

Mailing Address:

Grievance and Appeal Coordinator
P.O. Box 6029 Canton, OH 44706

Fax Number: 330-363-3066

Email Address: Appeals@aaltcare.com

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination, and all documents and correspondence related to this claim.



INTERNAL APPEAL REQUEST FORM

Name of person filing appeal _____

Relationship to covered person ☐ Covered Person/Applicant

☐ Authorized Representative (*please complete the Appointment of Authorized Representative section*)

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Mailing Address	City	State	Zip code
Daytime Phone	Evening Phone		
Email Address	Fax		

COVERED PERSON/APPLICANT INFORMATION

Name	ID Number		
Mailing Address	City	State	Zip code
Daytime Phone	Evening Phone		
Email Address	Fax		

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION

Name	Phone Number		
Mailing Address	City	State	Zip code
Email Address	Fax Number		
Contact Person	Phone Number		

Internal Appeal Specifications

1. Are you requesting an expedited appeal because your health, life, or ability to regain maximum function may be in serious jeopardy while you wait up to 30 days for a decision on your appeal? ☐ Yes ☐ No
2. Are you requesting an expedited appeal because your physician certifies that your pain cannot be controlled while you wait up to 30 days for a decision on your appeal? ☐ Yes* ☐ No

3. Are you requesting a Concurrent Expedited Internal Appeal and Expedited External Review and your physician certifies that it is necessary? (Note: Request for External Review form is not required.) ☐ Yes* ☐ No

*If you answer yes to question 2 or 3 above, your physician must certify that your condition could, in the absence of immediate medical treatment, result in any of the following:

- Seriously jeopardize your life, health, or your ability to regain maximum function, or
- Subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

You may also have your physician certify if you answer yes to question 1.

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

Signature of Covered Person (or legal representative**)

Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an appeal. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider, and/or health plan issuer to release all relevant medical or treatment records to an Independent Review Organization, the Ohio Department of Insurance, and/or my health plan issuer. I understand that the Independent Review Organization, the Ohio Department of Insurance, and/or my health plan issuer will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

Signature of Covered Person (or legal representative**)

Date

***Parent, Guardian, Conservator, or Other - please specify*

Send this form and a copy of your notice of final adverse benefit determination to one of the following:

Grievance and Appeal Coordinator

PO Box 6029 Canton, OH 44706 | Fax: 330-363-3066 | Email: Aappeals@aaultcare.com

Be certain to keep copies of this form, your Notice of Final Adverse Benefit Determination, and all documents and correspondence related to this claim.



REQUEST FOR REVIEW BY THE OHIO DEPARTMENT OF INSURANCE

Name of person filing request for review by the Ohio Department of Insurance _____

Relationship to covered person ☐ Covered Person/Applicant

☐ Authorized Representative (*please complete the Appointment of Authorized Representative section*)

How would you like us to contact you? ☐ Phone ☐ Fax ☐ Email ☐ Mail

CONTACT INFORMATION OF AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

COVERED PERSON/APPLICANT INFORMATION

Name		ID Number	
Mailing Address	City	State	Zip code
Daytime Phone		Evening Phone	
Email Address		Fax	

TREATING PHYSICIAN/HEALTHCARE PROVIDER INFORMATION

Name		Phone Number	
Mailing Address	City	State	Zip code
Email Address		Fax Number	
Contact Person		Phone Number	

To complete this request for review, please fill out the additional information on the reverse side.

Review Specifications

Briefly describe why you disagree with the decision to deny your request for external review. You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim.

Appointment of Authorized Representative (Complete when someone else is representing you in this appeal.)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my review by the Ohio Department of Insurance on my behalf.

Signature of Covered Person (or legal representative*)

Date

Signature and Release of Medical Records

To appeal the external review denial, you must sign and date this Request for Review by the Ohio Department of Insurance Form and consent to the release of medical records.

I, _____, hereby request a review of the external review denial. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider and/or health plan issuer to release all relevant medical or treatment records to the Ohio Department of Insurance. I understand that the Ohio Department of Insurance will use this information to make a determination on my request for review of the denial and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

Signature of Covered Person (or legal representative*)

Date

*Parent, Guardian, Conservator or Other - please specify

Send this form and a copy of your notice of denial of external review request for administrative reasons to one of the following:

Mailing Address:

Ohio Department of Insurance
ATTN: Consumer Affairs
50 West Town Street, Suite 300
Columbus, OH 43215

Phone Number: 1-800-686-1526 / 614-644-2658

TDD: 614-644-3745

Fax Number: 614-644-3744

Be certain to keep copies of this form, your Notice of Denial of External Review Request for Administrative Reasons and all documents and correspondence related to this review.



TREATING PHYSICIAN CERTIFICATION FOR EXPERIMENTAL/INVESTIGATIONAL ADVERSE BENEFIT DETERMINATIONS

NOTE TO THE TREATING PHYSICIAN

Covered persons may request an external review when a health plan issuer has denied a healthcare service or course of treatment that is considered experimental or investigational and is NOT explicitly listed as an excluded benefit under the covered person's health benefit plan. This form is for the purpose of providing the certification necessary to obtain a review. Please complete the entire form including the certification and return the executed form via one of the methods below.

MAILING ADDRESS

Attention: Grievance and Appeal Coordinator
P.O. Box 6029
Canton, Ohio 44706

Fax Number: 330-363-3066

Email Address: Appeals@aultcare.com

GENERAL INFORMATION			
Name of Covered Person/Patient		Covered Person's Health Plan ID Number	
Name of Treating Physician			
Licensure and Area of Clinical Specialty			
Mailing Address	City	State	Zip Code
Phone Number	Email Address		Fax Number
Contact Person		Phone Number	

External Review Specifications

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); and that I have requested the authorization for a drug, device, procedure, or therapy denied for coverage due to the health plan issuer's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements.

Continued on next page.

- In my medical opinion as the covered person’s treating physician, I hereby certify to the following (select all that apply):
- ☐ Standard healthcare services have not been effective in improving the condition of the covered person.
 - ☐ Standard healthcare services are not medically appropriate for the covered person.
 - ☐ There is no available standard healthcare service covered by the health plan issuer that is more beneficial than the requested healthcare service.

Please provide a description of the recommended or requested healthcare service or treatment that is the subject of the adverse benefit determination. Include any documentation that will be beneficial to the review process. Attach additional sheets as necessary.

Treating Physician Printed Name

Signature

Date



TREATING PHYSICIAN CERTIFICATION FOR INTERNAL APPEAL AND/OR EXTERNAL REVIEW

NOTE TO THE TREATING PHYSICIAN

Covered persons may request an internal appeal and/or external review when a health plan issuer has denied a healthcare service or course of treatment. The standard internal appeal and external review processes can take up to 30 days from the request date to the date a decision is rendered. Expedited appeals or reviews are only available under the circumstances shown below. This form is for the purpose of providing the certification necessary to obtain an expedited appeal or review. Please complete the General Information section along with the appropriate certification and return the executed form to one of the following:

MAILING ADDRESS

Attention: Grievance and Appeal Coordinator
P.O. Box 6029
Canton, Ohio 44706

Fax Number: 330-363-3066

Email Address: Aappeals@aultcare.com

GENERAL INFORMATION			
Name of Covered Person/Patient		Covered Person's Health Plan ID Number	
Name of Treating Physician			
Licensure and Area of Clinical Specialty			
Mailing Address	City	State	Zip Code
Phone Number	Email Address		Fax Number
Contact Person		Phone Number	

External Review Specifications

I hereby certify that I am a treating physician for _____ (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard internal appeal would, in my professional judgment, subject the covered person to severe pain that cannot be adequately managed without the requested care or treatment; and that, for this reason, the covered person's appeal should be processed on an expedited basis.

Continued on next page.

Treating Physician Printed Name

Signature

Date

Concurrent Expedited Internal Appeal and Expedited External Review Certification

I hereby certify that I am a treating physician for (hereafter referred to as "the covered person"); and (select all that apply):

- ☐ that adherence to the time frame for conducting an expedited internal appeal would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external review.
- ☐ that the recommended experimental or investigational treatment would, in my professional judgment, be significantly less effective if not promptly initiated; and that, for this reason, the covered person's expedited internal appeal should be conducted simultaneously with an expedited external review. I have attached the completed Treating Physician Certification Form for Experimental/Investigational Adverse Benefit Determinations.

Treating Physician Printed Name

Signature

Date

Expedited External Review Certification

I hereby certify that I am a treating physician for (hereafter referred to as "the covered person"); that adherence to the time frame for conducting a standard external review would, in my professional judgment, seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function; and that, for this reason, the covered person's external review should be processed on an expedited basis.

Treating Physician Printed Name

Signature

Date