2025

A guide to our services.

AULTCARE

8338/25

Helpful Tips

Things to have ready when you call us:

- Your AultCare ID Card, which has your group information and member ID number
- Your Explanation Of Benefits (EOB) form if you are calling about a claim (You can access your EOBs by going to www.aultcare.com and logging into your account.)

AultCare Service Center Contact Information

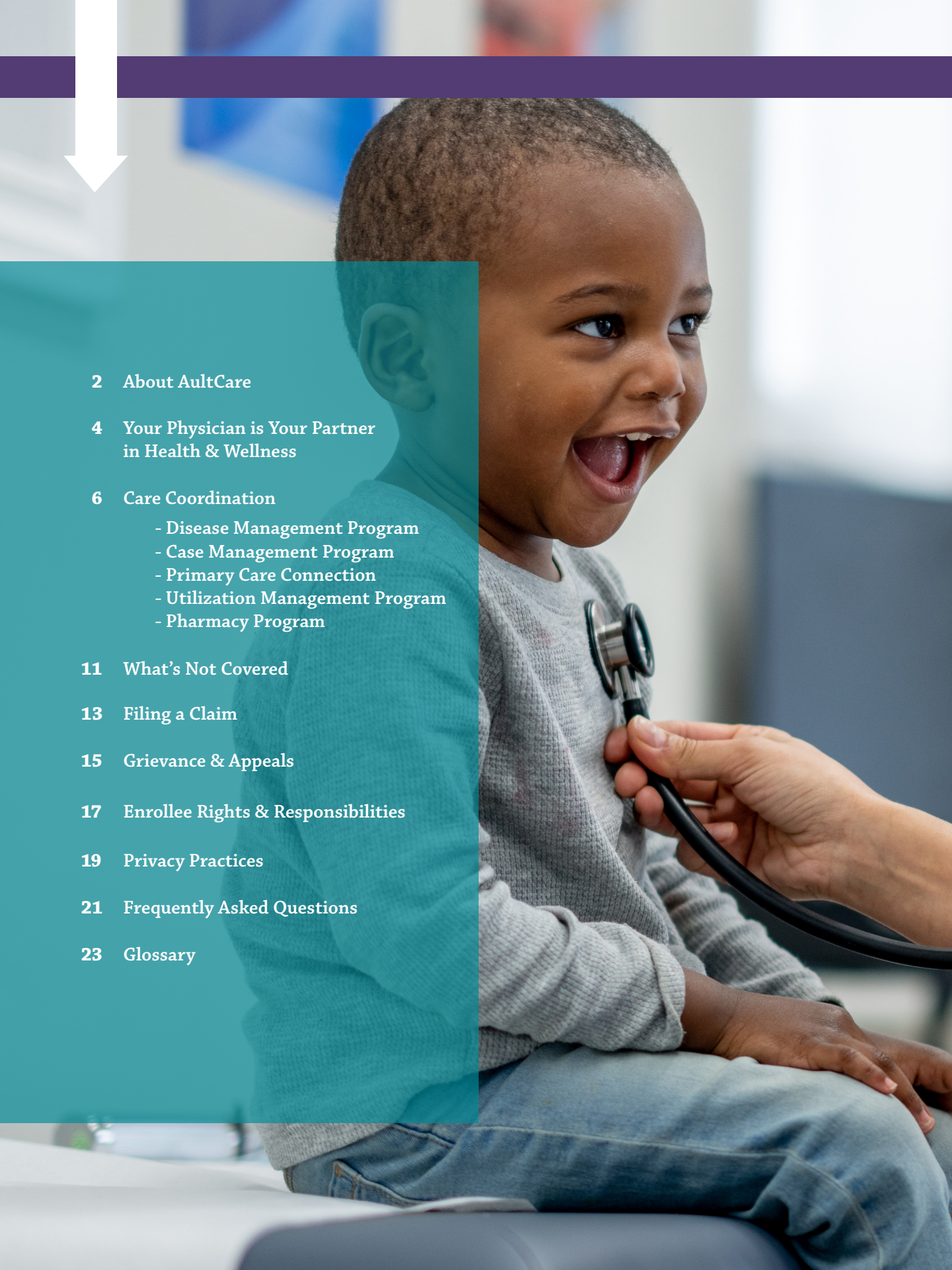
- 330-363-6360 (local)
- 1-800-344-8858 (toll-free)
- TTY users should call: 711
- Monday - Friday 7:30 am - 5:00 pm EST

Special Communication Needs

AultCare offers numerous services to meet the cultural and linguistic needs of our members. These services include access to translators of various foreign languages and a TTY line for the hearing impaired.

24-Hour Nurse Hotline Contact Information

- 330-363-7620
- 1-866-422-9603 (toll-free)



About AultCare.

For 40 years, AultCare has provided quality, affordable healthcare plans to the community it serves, through the use of innovative plan designs, superior customer service, and a high-quality network.

Going hand-in-hand with keeping healthcare costs affordable, is our dedication to health and wellness. We empower you with valuable resources to reduce your risk of disease and other costly health challenges. Of course, sometimes health issues are inevitable. We have programs and staff dedicated to managing those issues as well.

Healthcare doesn't need to be complex and confusing. Through our personalized customer service, AultCare guides you through the healthcare system with ease. We are proud to support all of our members, and serve as a trusted resource in the community.

Where You Matter

We believe your healthcare plan should be focused on your needs, in ways that matter to you. From the network you choose to how you receive communication from us, our plans and services are designed with you in mind so that you can take an active role in your health. When you are covered by AultCare, you are part of our local family!

When you call us, we pick up the phone. You won't get stuck in an automated answering system. When you have questions, we're here to help. We make it easy for you to get the answers you need. Meet with us in-person, call to speak with a knowledgeable customer service representative, or visit our website anytime at www.aultcare.com.

Advocate

We give you the tools and support to take control of your health. If you're diagnosed with a health condition, our experienced Care Coordination team can provide you with programs and services, tailored to your healthcare needs.

24-Hour Free Nurse Line

We offer you health information and support 24 hours a day, seven days a week. Call 330-363-7620 or toll-free 1-866-422-9603 to discuss your health-related questions or concerns with an experienced registered nurse. All calls are confidential.

Accurate

Accuracy is at the heart of what we do. In order to give you dependable information, we test our processes and streamline them for efficiency. Accurate answers are an essential part of our consistent, excellent service.

Recognition

The National Committee for Quality Assurance (NCQA) has awarded our Commercial PPO, Commercial HMO, Medicare HMO, and Marketplace PPO products with NCQA Health Plan Accreditation.

Answers

Prefer to use the internet? Our website, www.aultcare.com, is your health and wellness hub and the place to manage your account.

On the website, you can:

- Create an online account to manage your personal claim information, view your EOBs, download forms, and more
- Look for providers
- Find current health-related information
- Tell us what matters to you by taking satisfaction surveys

ACCREDITED NCQA HEALTH PLAN ACCREDITED
COMMERCIAL PPO

ACCREDITED NCQA HEALTH PLAN ACCREDITED
MEDICARE HMO-POS

ACCREDITED NCQA HEALTH PLAN ACCREDITED
COMMERCIAL HMO

ACCREDITED NCQA HEALTH PLAN ACCREDITED
EXCHANGE PPO

Your Physician is Your Partner in Health & Wellness

You should visit your primary care physician for regular checkups to maintain your best level of health and wellness.

Choosing a Doctor

When you join AultCare, you can see any doctor in the network. If you need specialty care, your Primary Care Physician (PCP) can identify network doctors who treat your condition. You can also go to our website to search for a doctor in our network.

Begin your search by visiting www.aultcare.com. You can identify and select network physicians according to the characteristics important to you, including:

- **Office location**
- **Language spoken**
- **Gender**
- **Specialty**
- **Hospital affiliations**
- **Acceptance of new patients**
- **Board certifications**

Customer service representatives are also available to help. They can help find a doctor who can meet your special or cultural needs.

Your physician may have more than one office. Alternate offices and locations of your physician may be considered outside the network. Please refer to the online Provider Directory at www.aultcare.com or contact the AultCare Service Center at 330-363-6360 or 1-800-344-8858 to confirm if an office is in-network.

Refer to your plan documents for your physical and wellness benefits and for specific information about access to providers.

If you need mental health and/or substance abuse services and do not have a mental health provider, please contact your primary physician. If your need is an emergency, go to the nearest emergency facility for evaluation. There are behavioral health providers available to you within your network.

In Case of Emergency

If you have a medical problem that must be treated right away and it is outside your physician's normal office hours, call his/her office and the physician on call will assist you.

If you have an emergency, call 911 or go to the nearest emergency care facility. You do not have to contact AultCare to obtain emergency services.

If you are out-of-town and need emergency care, please go to the nearest emergency care facility. If you become ill and you are out-of-town, and it is not an urgent or emergency situation, try to call your physician first. If that is not possible, seek treatment at the nearest medical care facility or physician's office. Notify the AultCare Service Center the next business day if you are admitted to an out-of-town hospital. Schedule an appointment with your physician for all follow-up care and services.

Some examples of emergency situations are:

- **High fever**
- **Convulsions**
- **Difficulty breathing**
- **Uncontrolled vomiting and/or diarrhea**
- **Broken bones**
- **Possible miscarriage or pregnancy with vaginal bleeding**
- **Poisoning**
- **Severe bleeding**
- **Severe burns**
- **Severe pain in the stomach or chest**
- **Shock**
- **Unconsciousness**

Remember, if you need emergency services:

1. **Go to the nearest emergency care facility. Be sure to present your AultCare ID card.**
2. **If you are admitted to the hospital, please make sure AultCare is notified on the next business day.**
3. **Remember to contact your PCP as soon as possible after your visit.**
4. **Schedule an appointment with your PCP for all follow-up care and services.**

Care Coordination

AultCare offers many health and wellness services to its members. These services are streamlined into a program known as Care Coordination. With Care Coordination, AultCare members have access to a team of local physicians, nurses, dietitians, pharmacists, and other clinical and non-clinical staff to help resolve any potential and ongoing health and wellness issues. This system allows AultCare to provide its members with a comprehensive approach to healthcare. Members may be affected by one or more programs provided by Care Coordination. The programs work collectively to cover all aspects of a member's health and wellness.

Disease Management Program

Provides members with education on prevention, ensuring members with chronic health issues have all the tools and services necessary to improve their health.

The Disease Management program offers an integrated and comprehensive approach to manage conditions, reduce complications, improve quality of life, and decrease costs. Disease Management nurses reach out to members with diagnoses such as Diabetes, Congestive Heart Failure (CHF), and Chronic Obstructive Pulmonary Disease (COPD) through telemonitoring programs. Outreach is also provided to members with mental health concerns through the Disease Management program.

Members will receive targeted materials to introduce available opportunities and AultCare Care Coordination resources. Nurses will also contact members for preventive care reminders and available educational programs. Common reminders AultCare nurses provide are preventive screenings, adherence follow-up, medication follow-up, and information on how to improve overall outcomes.

24-Hour Nurse Hotline

AultCare offers a health and information line to assist members with health-related questions day or night. By calling 330-363-7620, or toll-free 1-866-422-9603, you will be directed to an experienced registered nurse who is available 24 hours a day to answer your health-related questions and provide confidential information. They will be able to:

- **Provide first aid instructions and general health information**
- **Determine what level of care is most appropriate for your condition**
- **Answer your medication questions**
- **Offer suggestions for self-care**

Case Management Program

Provides education and assistance to members with complex medical needs

The Case Management program is made up of nurses and social workers who help members receive the care, information and community services they need. The program promotes quality, cost-effective outcomes through assessment, planning, coordination, education, and referral. AultCare case managers may contact members if they have recently had a long hospital stay, have a new cancer diagnosis, have a complex medical issue, or require specialized care from an out-of-network provider.

Primary Care Connection (PCC)

Serves as the link between the member, the primary care physician, and the health plan to help the member navigate the healthcare system and receive integrated care

AultCare's Primary Care Connection focuses on providing patient-centered, accessible, comprehensive, and coordinated care. PCC nurses connect with members over the phone or face-to-face for as long as needed. Education is offered to those dealing with chronic and acute conditions along with additional information and resources to ensure members' needs are met. The PCC team of nurses is the link between members, providers, and the health plan.

Utilization Management (UM)

Helps control healthcare costs through management of the use of healthcare resources

Pre-Certification

Pre-Certification, also known as pre-authorization or pre-approval, is the process of notifying your health plan prior to an elective hospital stay or elective surgery procedure. This process helps to determine that all medical care possibilities have been explored and are within acceptable time limits. The pre-certification process has two parts:

1. Notification - AultCare receives a request for services from your provider
2. Determination of coverage/verification of eligibility - we review your plan document and clinical information as it relates to the request for services

Getting pre-certification for a procedure does not mean the service will be covered and paid at the highest level of benefit, or at all.

All claims are subject to review upon receipt of the actual claim or documentation and are subject to updates in eligibility upon receipt of the actual claim.

Refer to your plan documents, access our website at www.aultcare.com or contact the AultCare Service Center to determine if your particular plan has additional pre-certification requirements or to obtain a list of items requiring pre-certification.

Reference Based Pricing vs. Usual Customary Reasonable Allowances

All benefits are subject to Reference Based Pricing (RBP) or Usual Customary and Reasonable Allowances (UCR). Amounts exceeding RBP or UCR for services rendered by a network provider are not patient responsibility. Amounts exceeding the RBP or UCR for services rendered by a non-network provider or for services rendered under a traditional plan in the absence of a provider network, may be the financial responsibility of the patient. If you have questions regarding this information, please contact the AultCare Service Center. Please refer to your Certificate or Plan Document and Summary Plan Description for details on your coverage.

Utilization Management Evaluation of New and Existing Technology

AultCare investigates all requests for coverage of new technology using a medical technology assessment company as a guideline. If additional information is needed, AultCare utilizes sources including, but not limited to Medicare and Medicaid policies and Food and Drug Administration releases of any current medical peer review literature. This information is reviewed and evaluated by AultCare's medical director and other physician advisors in order to determine if a new technology is appropriate for coverage under your AultCare plan. Members may request that a certain new technology be investigated for coverage by contacting the UM department.

How to Submit a Request for Pre-Certification

Requests should be submitted by phone, fax or in writing to:

AultCare Care Coordination
P.O. Box 6910
Canton, Ohio 44706
Phone: 330-363-6360 or 1-800-344-8858
Fax: 330-454-9635

Denials are documented in the form of a letter to you and the requesting provider. The letter includes:

- **The specific reason for denial**
- **Reference to the benefit provision, guideline, protocol or other similar criteria on which the denial decision is based**
- **Decision of additional information needed to analyze the request**
- **Notification that you can obtain a copy of the actual benefit provision, guideline, protocol or criteria on which the denial was based (this is upon request and at no extra cost)**
- **Description of your appeal rights and appeal process, including your right to have an authorized representative act on your behalf**
- **A description of the expedited appeal process if the denial is urgent pre-service or urgent concurrent review**

If the denial is based on medical necessity, a reviewer is available to discuss the decision with the physician or provider.*

AultCare provides you with access to staff to discuss the UM process and any issue relating to the UM process. Professional staff members are available from 8 a.m. to 5 p.m. Monday - Friday by contacting the AultCare Service Center at 330-363-6360 or toll free at 1-800-344-8858. TTY users should call: 711. If you call after business hours, please leave a message and we will respond to your call the next business day.

****Emergency care does not require pre-certification.***

Pharmacy Program

This information only applies if AultCare is your pharmacy benefit administrator

AultCare's pharmacy program provides you with a variety of safe, effective and affordable prescription choices to meet your medication needs. Find out what medications are covered under your plan by accessing your plan's formulary at www.aultcare.com or by contacting AultCare Customer Service. The formulary is a list of medications your plan covers based on evaluations of efficacy, safety, and cost-effectiveness.

If your pharmacy benefits are covered under a copayment structure, you will save money by asking your doctor if your prescription can be filled with a generic equivalent or by choosing drugs in the lowest-cost tiers of your plan design. Talk to your doctor about which prescriptions will work best for you. Generic medications, with the lowest copayments, are affordable alternatives that have met multiple quality and safety standards set by the FDA.

For certain prescription drugs, AultCare has additional requirements for coverage.

These requirements ensure the drug prescribed is clinically appropriate for the plan member and also helps us manage drug plan costs. A team of physicians and pharmacists developed these requirements for our plan to help us provide quality coverage to our members. For a current listing of medications that require prior authorization, please visit the website at www.aultcare.com or call customer service at 330-363-6360 or 1-800-344-8858.

Mail Order

Some AultCare plans include the option to have your prescriptions filled by mail-order.

A mail-order option offers you an alternative to the retail pharmacy for long-term medications. With mail-order service, you have the convenience of home delivery and the ability to refill orders online, by phone, fax, or mail.

To have your prescription filled by mail-order, simply ask your physician for a new prescription. Check your plan documents to see how many days supply your plan will cover.

Mail your prescription to your mail-order vendor/pharmacy, or have your physician fax it. Please refer to your individual schedule of benefits to determine your actual copayment. Most plans allow up to a 60 or 90-day supply by mail-order. To obtain information regarding the mail-order services, please call AultCare at 330-363-6360 or visit the Pharmacy Services page on our website at www.aultcare.com.

Prior Authorization/Step Therapy

Certain medications require prior authorization or step therapy, meaning your physician must consult with AultCare before prescribing a medication for you for the first time.

For a current listing of medications requiring prior authorization, visit the Pharmacy Services page at www.aultcare.com.

Medication Safety

The medications you take are an important part of your health. AultCare has compiled guidelines you can use to help your doctor and pharmacist provide you with quality healthcare. They are as follows:

- **Keep an updated list of all the medications you take (including prescription, over-the-counter, herbal remedies and supplements).**
- **Make sure all of your doctors know all of the medications you are taking.**
- **Read prescription labels carefully and always follow the directions exactly. If you have questions about a prescription, such as side effects or interactions with other medications or food, ask your doctor or pharmacist. If a medication you've taken before looks different, notify your pharmacist immediately.**
- **When you get a new prescription ask your doctor if it replaces any of your current medications.**
- **Keep medications in their original container, unless you use a pill organizer.**
- **Discard all expired medications properly.**
- **Whenever possible, use only one pharmacy. This will ensure you do not take conflicting medications. If you use both retail and mail order pharmacies, make sure each pharmacy is aware of all your medications and allergies.**

What's Not Covered

Members should refer to their plan documents to determine which healthcare services are covered and to what extent.

The following is a partial list of services that are usually NOT covered. However your plan documents may contain exceptions to this list based on state mandates or the plan design purchased.

- **All medical and hospital services not specifically covered in, or which are limited or excluded in your plan documents, including costs of services before coverage begins and after coverage ends**
- **Care, services or supplies which are not deemed medically necessary**
- **Treatment, services or procedures that are experimental, or investigative**
- **Non-rehabilitative chiropractic services**
- **Dental care, except as specifically stated in the benefit descriptions**
- **Eyeglasses, contact lenses, hearing aids and their fittings, and hearing tests except as specifically stated in the benefit descriptions**
- **Radial keratotomy, lasik, or related procedures**
- **Cosmetic surgery, except as specifically stated in the benefit descriptions**
- **Respite, custodial, and residential care except as specifically stated in the benefit descriptions**

- **Sterilization reversal and some infertility processes and related services**
- **Implantable drugs and certain injectable infertility drugs**
- **Physical, mental or substance abuse examinations done for or ordered by third parties**
- **Immunizations for travel or work**
- **Over-the-counter medications and supplies**
- **Marital counseling**
- **Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling**

Most plans exclude all forms of gastric restrictive procedures for the purpose of weight loss/control. Check your specific plan or contact the AultCare customer service to determine if these procedures are covered under your specific plan.

You must consult your specific plan document. Contact AultCare customer service if you have additional questions.

We Want Your Feedback

As a part of our AultCare family, your opinions are important to us. What our members tell us helps us to evaluate our services and processes, and make improvements when needed.

- **New Enrollee Survey**
- **Member Satisfaction**

Ways you can complete a survey:

The surveys can be taken two ways: online or printed and a paper copy returned by mail. To take the survey online, log into your AultCare online member account. Register for a new account if you do not have one. Once logged in, the survey link will appear at the bottom of your screen.

If you do not have internet access, but would still like to participate, contact the AultCare customer service to request a paper copy.

As always, your answers are confidential, anonymous, and in no way will affect your coverage.

Filing a Claim

Physician Claims

You do not need to send in claim forms when you use network providers. As long as you use network providers, your physician will submit claims to AultCare for you.
If your doctor is not a network provider, call AultCare Utilization Management at 330-363-6360 or 1-800-344-8858. In some cases, we may continue to pay for covered services at the network provider rate for a limited period of time to let you complete a course of treatment. We also will help you find an in-network provider or you may reference our provider directory at *http://www.aultcare.com/findaprovider.*

If you have an approved referral to a non-network provider, those services may be covered at the same level as network providers. All benefits are subject to Reference Based Pricing (RBP) or Usual Customary and Reasonable Allowances (UCR). Amounts exceeding RBP or UCR for services rendered by a network provider are not patient responsibility. Amounts exceeding the RBP or UCR for services rendered by a non-network provider or for services rendered under a traditional plan in the absence of a provider network, may be the financial responsibility of the patient. If you have questions regarding this information, please contact the AultCare Service Center. Please refer to your Certificate or Plan Document and Summary Plan Description for details on your coverage.

If your non-network provider does not send in your claim, you should:

1. **Fill out the Application for Benefits form**
2. **Include a copy of the bill from your non-network provider**
3. **Mail the forms to AultCare at the address below:**

AultCare
P.O. Box 6910
Canton, Ohio 44706

Application for Benefits

You can get a copy of the Application for Benefits form on AultCare's website at *www.aultcare.com* or by calling customer service at 330-363-6360 or 1-800-344-8858.

A separate Application for Benefits form is needed for each bill. Be sure to complete all sections of the form that apply to your situation and sign it.

Hospital Claims

When you receive services at a hospital, show your AultCare ID card. The hospital will send the claim information to AultCare.

Application for Benefits

You will need to show your ID card when you go to a provider for services. Your provider will use the information on the card to verify coverage. If your coverage changes, you might receive a new ID card. Use the most current card as reflected by the effective date on the card.

Keep Your Records Up to Date

We need current information about you and your dependents to accurately pay claims. Outdated or incorrect information can cause mistakes, delays in payment or denial of coverage.

Updating Your Records

Tell your employer (groups) or AultCare (individuals) within 31 calendar days if there are changes in your:

- **Name**
- **Address**
- **Phone number**
- **Marital status**
- **Family status, including information about your dependents, new dependents, changes in family status or who is to be covered by the health plan**

Remember: Notify your employer of changes, additions, or to end coverage as soon as possible.

Grievances and Appeals

How to let AultCare know if you are dissatisfied or disagree with a decision about your benefit coverage.

Use this information to let AultCare know if you are dissatisfied or disagree with a decision about your benefit coverage. If you are dissatisfied with AultCare or your network providers, please contact us as soon as possible. Your concerns will be forwarded to the Grievance Department who will conduct a thorough investigation and provide a written response to you within 30 days. This is known as the Grievance Process. You may contact AultCare customer service to voice your concern or you may also put your grievance in writing to the attention of:

AultCare Grievance and Appeal Department
P.O. Box 6029
Canton, Ohio 44706

If you disagree with a determination about a specific benefit, you have the right to appeal AultCare's decision. This is known as the Appeals Process. The appeal process can be initiated by you, your provider, or your authorized representative. Your appeal must be submitted within 180 calendar days of the adverse determination and should contain a statement describing the reasons why you feel your claim/services should not have been denied, in addition to written comments, documents, records, or other information relating to the claim/service. A full and fair review will be conducted, taking into consideration all of the information received with the appeal. Clinical appeals, or appeals relating to decisions based on medical necessity, are conducted by health professionals who are:

- **The same or similar specialty as the servicing physician or requesting provider**
- **Board-certified, if applicable**

Appeals will not be reviewed by the individual who made the original decision nor will they be a subordinate of that person. Appeal decisions are based only on appropriateness of care and the existence of coverage. AultCare does not specifically reward practitioners of care or other individuals for issuing denials of coverage or service care.

AultCare will provide a written notification detailing the outcome of your appeal. The timeframe for the appeal response is dependent on the type of appeal filed. Timeframes and descriptions of appeal types are as follows:

Pre-Service Appeal:

An appeal filed prior to receiving the requested service. Notification of a decision will be issued within 30 days of our receipt of your appeal.

Post-Service Appeal:

An appeal filed after services have been received. Notification of a decision will be issued within 60 days of our receipt of your appeal.

Urgent Appeal:

An appeal, if not answered expeditiously, could seriously jeopardize your health. You will be notified of our decision as soon as possible, but no later than 72 hours of our receipt of your appeal.

Appeals can be mailed to:

AultCare Grievance and Appeal Department
P.O. Box 6029
Canton, Ohio 44706

AultCare communicates your appeal rights in many ways to ensure each member understands their rights. Your plan documents, your Explanation of Benefits, and a benefit denial letter describe your appeal rights as an AultCare member. Every member is granted the same first level of appeal rights or internal review. If you initiate a first-level appeal and we uphold our original decision, your resolution letter will outline your additional appeal rights, which may include external review rights. Your rights vary depending on state and federal laws.

For more information on your appeal rights, you can review your plan document, Explanation of Benefits, benefit denial letter, appeal resolution letter or contact AultCare customer service for a copy of your appeal procedure at 330-363-6360 or toll-free 1-800-344-8858.

Enrollee Rights & Responsibilities

Quality healthcare benefits are responsibilities shared with your doctors and your plan. We want you to know your rights and responsibilities. Please read your plan documents for a full description. If you have a question, concern, or a recommendation for how AultCare could improve its policies for promoting enrollee responsibilities and rights, contact us through our website at www.aultcare.com or call customer service at 330-363-6360 or toll-free at 1-800-344-8858.

You have a responsibility to:

- Take your AultCare ID card when you go to the doctor, hospital, drug store, or healthcare provider. It contains important information. Having your card may help save time and prevent mistakes.
- Tell the doctor or nurse about your condition. Tell your doctor what medications you are taking. Answer any questions the doctor or nurse may ask you truthfully. This information may help your doctor form treatment goals and alternatives. Understand your health problems and participate in developing mutually agreed-upon goals.
- Ask questions if you do not understand something about your medical condition and the treatment alternatives (including medications) the doctor is recommending.
- Follow your doctor's medical advice and instructions. Take medications as directed. Let the doctor know if you have a bad reaction. Let your doctor know if your symptoms do not get better, or if they get worse. Schedule recommended follow-up appointments.

- Live a healthy lifestyle.
- Check your Schedule of Benefits.
- Let your employer (groups) or AultCare (individuals) know if there are changes with you and your dependents.
- Obtain all required pre-approvals (pre-certifications) and second opinions.
- Ask your employer or call AultCare if you have questions about your coverage or responsibilities.

You have a right to:

- Receive information about the organization, its services, its practitioners and providers, and member rights and responsibilities.
- Receive information about your coverage and services (see your plan documents).
- A list of doctors, hospitals, and other AultCare network providers. Visit our website at www.aultcare.com or call AultCare customer service.
- Be treated with dignity and respect.
- A frank discussion with your doctor about your medical condition, including appropriate and medically necessary treatment options, regardless of cost or benefit coverage and to participate in making decisions about your healthcare. Your doctors are independent. They are not restricted or prohibited from discussing treatment options with you, including those not covered.

- **Privacy of your healthcare and claims information. Your Protected Health Information will be used to pay claims, as permitted by HIPAA and as described in your Notice of Privacy Practices. Protected Health Information will not be disclosed to others without your authorization, except as permitted by HIPAA and state law.**
- **Ask questions, raise concerns, make complaints, and appeal denials, as explained in your certificate or benefits booklet.**
- **Make recommendations about AultCare's Member Rights and Responsibilities Policy.**
- **Request accommodation if you have limited knowledge of the English language.**

Privacy Practices

Notice of Privacy Practices

AultCare, on behalf of AultCare Insurance Company, maintains a Notice of Privacy Practices that provides information on the use and disclosure of Protected Health Information (PHI). This notice is available on our website www.aultcare.com. If you would like a copy of AultCare's Notice of Privacy Practices, please contact customer service at 330-363-6360 or toll-free at 1-800-344-8858.

AultCare prides itself on ensuring our members' PHI is maintained with appropriate privacy and confidentiality. All employees are held to internal standards of protecting written, oral, and electronic PHI. Use and Disclosure of PHI to plan sponsors is handled with security and certification the plan sponsor agrees to AultCare's policies on PHI.

AultCare maintains a Notice of Privacy Practices that provides important information on the Use and Disclosure of PHI and your rights regarding your PHI. Highlights from the notice are outlined on the right.

Uses and Disclosures

Unless permitted by state or federal law, we will not use or disclose your protected health information for any purpose without your express written authorization. You have the right to revoke that authorization and we will take every effort to honor those requests.

We are permitted or required by law to make certain uses and disclosures of your protected health information without your authorization. For a detailed list of the uses and disclosures that do not require your authorization, please review the Notice of Privacy Practices. Examples of such uses and disclosures include:

- **Treatment**
- **Payment**
- **Healthcare operations**

Access to Your Protected Health Information

You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative.

Restrictions on Use and Disclosure of Your Protected Health Information

You have the right to request restrictions on certain uses and disclosures of your protected health information for treatment, payment, or healthcare operations by notifying us of your request for a restriction in writing.

Amendments to Your Protected Health Information

You have the right to request in writing an amendment or correction to the protected health information we maintain about you. We are not obligated to make all requested amendments, but we will give each request careful consideration. All amendment requests should be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request.

Accounting for Disclosures of Your Protected Health Information

You have the right to receive an accounting of certain disclosures made by us of your protected health information after April 14, 2003. Requests should be made in writing and signed by you or your representative.

Please review the Notice of Privacy Practices for more detailed information on our Use and Disclosure of Protected Health Information. The Notice of Privacy Practices and the necessary request forms are available on our website at www.aultcare.com/aultcare-privacy. If you would like a copy of the notice or the request forms, please contact customer service at 330-363-6360 or toll-free at 1-800-344-8858.

Frequently Asked Questions

Q. Do I need a Primary Care Physician (PCP)?

A. We recommend you have a PCP to help guide you in your healthcare needs.

Q. How can I find a doctor? How do I find a doctor in my network?

A. You may search for network doctors in various ways:

- Visit the AultCare website at www.aultcare.com. Click on the 'Find A Provider' button at the top of the page. Select the ID card that matches the ID card you have to search the correct network directory.
- Call AultCare customer service.

When making an appointment with your doctor, be sure to confirm the doctor or provider is still a network provider.

Q. What if my PCP cannot provide the care I need?

A. Your doctor may refer you to a specialist. If the recommended specialist is in your network, no additional actions are necessary.

Q. What if my doctor refers me to an non-network doctor?

A. If the specialist is not in the network, your network doctor will need to provide detailed information to AultCare Utilization Management and request an approval before you seek treatment.

Q. My PCP or network doctor has sent a request for my treatment with a non-network doctor. How will I know if my treatment was approved?

A. You will receive a letter from AultCare Utilization Management. The letter will tell you if your treatment has been approved at the network level of benefits, or if it has been denied (for PPO plans, services can be partially approved, which means the services have been approved at the non-network level of benefits).

If you receive care from a non-network provider, you may have to pay a different deductible and/or coinsurance. You will be responsible for paying any difference between what the provider charges for the service and what the plan allows.

Q. The letter approving my care at the network level of benefits mentioned UCR and RBP. What does this mean?

A. This means that the non-network treatment requested by your network doctor has been approved at the network level of benefits, and is payable based on Reference Based Pricing (RBP) or the Usual, Customary and Reasonable (UCR) schedule of charges.

Q. What do UCR and RBP mean?

A. UCR is a schedule of average fees most providers in the area charge for a given procedure. It affects insurance reimbursement and out-of-pocket charges you might have to pay. RBP (Reference Based Pricing) refers to the allowable fees for covered services. In regards to a non-network provider, RBP is a fee level assigned based on a percentage or multiple of the allowed amount Medicare would pay for a covered service. If there is no corresponding Medicare rate for the covered service, AultCare determines an appropriate fee for that covered service. If your provider charges more than the UCR OR RBP, you will be responsible for paying the difference between what the provider has charged and the UCR or RBP amount that will be used to pay your benefits.

Q. Will I owe the amounts over UCR?

A. Yes. The amounts over UCR are not covered by your plan. You are responsible for those amounts. We suggest discussing payment options with your provider.

Q. I received a letter that the recommended treatment was not approved. What does this mean?

A. Although the treatment may be recommended by your doctor, it may not be covered under your plan. If your referral is not approved, there is not reduced coverage for the treatment under your plan. Always refer to your plan document for specific limitations that apply. Refer to page 15 for your appeal rights.

Q. What if I need help understanding my approval/denial letter content?

A. Contact Utilization Management at 330-363-6360 or 1-800-344-8858. Refer to your plan document for specific limitations that apply. Refer to page 15 for your appeal rights.

Q. What if I need after-hours care in or out of the area?

A. If you need care after hours, contact your physician's office. If you feel your needs are urgent or your situation is an emergency, proceed to the nearest emergency room, urgent care center, or call 911.

Q. How do I view my medical benefits online?

A. Go to *www.aultcare.com*

- Log into your account
- Click on "Eligibility"
- Select "Member" from the drop-down box
- Select "Active" from the Status drop-down box
- Click "Search"
- Select plan to see benefits

OR

Call customer service at 330-363-6360 or toll free at 1-800-344-8858
TTY users should call: 711.

Glossary

This glossary defines many commonly used terms, but it is not a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms may not have the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)

Allowed Amount– This is the maximum payment the plan will pay for a covered healthcare service. May also be called "eligible expense," "payment allowance," or "negotiated rate."

Appeal– A request for your health insurer or plan to review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing– When a provider bills you for the balance remaining on the bill your plan does not cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

Claim– A request for a benefit (including reimbursement of a healthcare expense) made by you or your healthcare provider to your health insurer or plan for items or services you think are covered.

Coinsurance– Your share of the costs of a covered healthcare service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)

Complications of Pregnancy– Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section generally are not complications of pregnancy.

Copayment– A fixed amount (for example, $15) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Cost-Sharing– Your share of costs for services a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs").

Some examples of cost-sharing are copayments, deductibles, and coinsurance. Family cost-sharing is the share of cost for deductibles and out-of-pocket costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan does not cover usually are not considered cost-sharing.

Cost-Sharing Reductions– Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you are a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible– An amount you could owe during a coverage period (usually one year) for covered healthcare services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered healthcare services subject to the deductible.)

Diagnostic Test– Tests to figure out a health problem. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)– Equipment and supplies ordered by a healthcare provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition– An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you did not receive medical attention right away. If you did not receive immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; 2) You would have serious problems with your bodily functions; 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation– Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services– Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

Excluded Services– Healthcare services that your plan does not pay for or cover.

Formulary– A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost-sharing levels or tiers.

For example, a formulary may include generic drug and brand name drug tiers and different cost-sharing amounts will apply to each tier.

Grievance– A complaint communicated to your health insurer or plan.

Habilitation Services– Healthcare services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance– A contract that requires a health insurer to pay some or all of your healthcare costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan."

Home Healthcare– Healthcare services and supplies you receive in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed healthcare providers. Home healthcare usually does not include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services– Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization– Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care– Care in a hospital that usually does not require an overnight stay.

Individual Responsibility Requirement– Sometimes called the "individual mandate," the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you do not have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

In-Network Coinsurance– Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

In-Network Copayment– A fixed amount (for example, $15) you pay for covered healthcare services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Marketplace– A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; and choose a plan and enroll in coverage.

Also known as an "Exchange." The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-Pocket Limit- Yearly amount the federal government sets as the most each individual or family can be required to pay in cost-sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of-pocket limits stated for your plan.

Medically Necessary- Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage- Health coverage that will meet the individual responsibility requirement. Minimum essential coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage.

Minimum Value Standard- A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost-sharing reductions to buy a plan from the Marketplace.

Network- The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.

Network Provider (Preferred Provider)- A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider in the network. Also called "preferred provider" or "participating provider."

Orthotics and Prosthetics- Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

Out-of-Network Coinsurance- Your share (for example, 40%) of the allowed amount for covered healthcare services to providers who do not contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment- A fixed amount (for example, $30) you pay for covered healthcare services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Network Provider (Non-Preferred Provider)- A provider who does not have a contract with your plan to provide services. If your plan covers out-of-network services, you will usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider."

Out-of-Pocket Limit– The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for healthcare costs. This limit never includes your premium, balance-billed charges or healthcare your plan does not cover. Some plans do not count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

Physician Services– Healthcare services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan– Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain healthcare costs. Also called "health insurance plan," "policy," "health insurance policy" or "health insurance."

Preauthorization– A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization is not a promise your health insurance or plan will cover the cost.

Premium– The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits– Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you receive health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

Prescription Drug Coverage– Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

Prescription Drugs– Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)– Routine healthcare, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician (PCP)– A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of healthcare services for you.

Primary Care Provider– A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of healthcare services.

Provider– An individual or facility that provides healthcare services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The plan may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery– Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

RBP (Reference Based Pricing)– Refers to the allowable fees for covered services. In regards to a non-network provider,RBP is a fee level assigned based on a percentage or multiple of the allowed amount Medicare would pay for a covered service. As with the application of UCR, RBP is applied to non-network providers and facilities which are not obligated to accept this amount as payment. This may result in balance billing to the member. If there is no corresponding Medicare rate for the covered service, AultCare determines an appropriate fee for that covered service.

Referral– A written order from your Primary Care Provider for you to see a specialist or receive certain healthcare services. In many Health Maintenance Organizations (HMOs), you need to obtain a referral before you can receive healthcare services from anyone except your Primary Care Provider. If you do not receive a referral first, the plan may not pay for the services.

Rehabilitation Services– Healthcare services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening– A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care– Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist– A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug– A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a healthcare professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

UCR (Usual, Customary and Reasonable)– The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care– Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

AultCare/Aultra Notice Tag Lines for the State of Ohio

English
This Notice has Important Information**.** This notice has important information about your application or coverage through **AultCare /Aultra.** Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. **Call Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 711 Outside Stark County: 711**

Spanish
Español
Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través **AultCare/Aultra.** Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. 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
本通知有重要的訊息。本通知有關於您透過 **AultCare/Aultra 保险公司** 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。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
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch **AultCare/Aultra**. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 711 Außerhalb von Stark County : 711**

Arabic
العربية
يحوي هذا الاشعار معلومات هامة. يحوي هذا الاشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلا شركة التأمين AultCare/Aultra
ابحث عن التواريخ الهامة في هذا الاشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصور على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ330.363.6360 خارج مقاطعة ستارك :1.800.344.8858 لخط **TTY**المحلي: 711 خارج مقاطعة ستارك :711

Pennsylvania Dutch
Deitsch
Die Bekanntmaching gebt wichdichi Auskunft. Die Bekanntmaching gebt wichdichi Auskunft baut dei Application oder Coverage mit **AultCare/Aultra**. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmde Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY – Linie Local: 711 Außerhalb von Stark County : 711**.

Russian
русский
Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через **Страховая компания AultCare/Aultra**. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 711 Вне Старка County : 711.**

French
Français
Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de **Compagnie d'Assurance AultCare/Aultra**. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. **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**

Vietnamese
Việt Nam
Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình **Công ty Bảo hiểm AultCare/Aultra**. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 711 Bên ng oài của Stark County : 711.**

Cushite-Oromo

AultCare/Aultra Notice Tag Lines for the State of Ohio

Beeksisni kun odeeffannoo barbaachisaa qaba**.** Beeksisti kun sagantaa yookan karaa **AultCare/Aultra** tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 711 Outside of Stark County: 711** tii bilbilaa.

Korean

한국어

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 **AultCare/Aultra 보험 회사계획** 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. **지역 : 330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 711 스타크 카운티 의 외부 : 711** 로 전화하십시오.

Italian

Italiano

Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso **AultCare/Aultra**. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama **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.**

Japanese

日本語

この通知には重要な情報が含まれています。この通知には **AultCare/Aultra** 保険会社 の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。**330.363.6360** スタークの外： **1.800.344.8858 TTY** ライン ローカル： **711** スタークの外： **711** までお電話ください。

Dutch

Nederlands

Deze mededeling heeft belangrijke informatie. Deze mededeling heeft belangrijke informatie over uw aanvraag of dekking via **AultCare /Aultra.** Kijk naar belangrijke datums in deze mededeling. Het kan nodig zijn om actie te ondernemen binnen bepaalde termijnen om uw zorgverzekering te behouden of hulp met kosten te krijgen. U heeft het recht op deze informatie en hulp in uw taal zonder kosten. Bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 711 Buiten Stark County : 711.**

Ukrainian

український

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