Claims Payment Policies and Practices (Small Group)

Out of network liability and balance billing:

When you choose a Non-Network Provider, you may not receive the same Level of Benefits. Charges that exceed the Reference Based Pricing rates (also called "RBP.") are not covered. You may be billed for charges that exceed RBP. This is called balance billing. You may need to pay more Out-of-Pocket Expenses, unless certain protections, as described below, apply.

Exceptions to out of network liability:

The Plan will cover services for an Emergency Medical Condition treated in any hospital emergency department. If applicable, Emergency Services will be covered according to Your Benefits Chart no matter when or where you receive them. Plans will not require prior authorization or impose any other administrative requirements or benefit limitations that are more restrictive than services received from a Network provider.

Additionally, the Plan adheres to state and federal surprise billing protections. These protections ensure you will not be balanced billed for Emergency Services, certain services from Non-Network Provider received at a Network Facility. Additionally, you should not be balanced billed for air or ground ambulance services

There may be times that services are necessary to be provided outside of the network. In order for services to be covered at the higher level of benefit, you must obtain approval before receiving the service. See Pre-Approval section below.

Whether an enrollee may be balance billed:

If you seek non-Emergency services from a Non-Network Provider, you may be billed for charges that exceed Reference Based Pricing. This is called balance billing. For example: If a Non-Network Provider charges you a fee of $125 for a procedure, and the RBP amount We have determined for this procedure is $100, then We will pay up to the RBP amount ($100), minus Your co-pay and co-insurance. You would be responsible for paying the amount that exceeds RBP, which is $25 plus any Cost Share. You are not responsible for paying any amount that exceeds the negotiated rate when you go to a Network Provider.
There may be instances in which you may seek services from an out-of-network provider and give informed consent to that provider to receive those out-of-network services and to be balanced billed.

Enrollee claims submission:

Your Network Provider will file Your Claim for You. If you go to a Non-Network Provider, you may need to use an application for Benefits form. You can get a copy of this form on-line by going to our website www.aultcare.com clicking this link https://www.aultcare.com/assets/Claim-Forms/Medical-Rx-Claim-Form-AultCare.pdf or by calling us at 330-363- 6360 (TTY: 711) or 1-800-344-8858. Fill it out and sign the top half of this form. Be sure to answer all questions. Give the form to the Non-Network Provider

and ask him or her to complete the bottom half. Either You or the Non-Network Provider must then send the completed form to us at the AultCare Service Center, P.O. Box 6910, Canton, Ohio 44706. In some cases, you may be able to attach an itemized statement from Your Non-Network Provider instead of having the Non-Network Provider complete the bottom half of the form.
Generally, you must file a Claim within **12-24** months from the date you received Service, unless you are not reasonably aware that it must be filed because of Coordination of Benefits or Subrogation.

Enrollee rights:

You have a Right to:

1. Receive information about the organization, its services, its practitioners and Providers, and Member rights and responsibilities.
2. Receive information about Your Coverage and services.
3. A list of Doctors, Hospitals, and other Network Providers. See our website, www.aultcare.com.
4. Be treated with dignity and respect.
5. 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 health care. Your Doctors are independent. They are not restricted or prohibited from discussing treatment options with you, including those that are not covered.

6. Privacy of Your health care 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.
7. Ask questions, raise concerns, make Complaints, and Appeal Denials as explained in Your Certificate or Benefits booklet.
8. To make recommendations about AultCare's Member Rights and Responsibilities Policy.
9. Request accommodation if you have limited knowledge of the English language.

Enrollee responsibility

You have a Responsibility to:

1. Bring your AultCare ID card when you go to the doctor, hospital, drug store, or health care provider. It contains important information. Having your card may help save time and prevent mistakes.
2. 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 completely and truthfully. This information may help your doctor form treatment goals and alternatives. Understand your health problems and participate in developing mutually agreed upon goals.
3. Ask questions if you do not understand something about your medical condition and the treatment alternatives (including medications) the doctor is recommending.
4. 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.
5. Live a healthy lifestyle.
6. Check your benefit chart (schedule of benefits).

7. Let your employer know if there are changes with you and your dependents.
8. Get all required pre-approvals (pre-certification) and second opinions.
9 Ask your employer, or call AultCare, if you have questions about your coverage or responsibilities.

Grace periods and claims pending:

This is a stated period of time during which premium may be paid after the due date to keep the plan in force. If you are not receiving an advance premium tax credit, and you have paid at least one full month's premium during the benefit year including the latest payment period, we will offer a 30 day grace period prior to terminating your coverage back to the last day through which coverage was paid. If you are receiving an advance premium tax credit, and you have paid at least one full month's premium during the benefit year including the latest payment period, we will offer a 3 month grace period prior to terminating your coverage. If payment is not made in full for the outstanding balance by the end of the 3 month grace period, your coverage will be terminated back to the last day of the first month of your grace period.
An explanation of what claims pending is – When the member is in the first month of grace, we pay the claim to the provider, but attach a remark code that advises the provider that the member is currently in grace and this might affect future claim payments. During months two and three of the grace period, we do not pay and address the claims to the provider with the same remark code. If the member brings their account balance back to "fully whole", we process any previous claims for payment. If they do not get caught up on premiums, we go back to the claims from months two and three and deny them due to no coverage. Their policy is terminated to the last day of the first month of grace, but we are required to leave the payments made during that first month and we do not request refunds on those

Claims processing policies during grace period:

We will do the following during your grace period:
1. Pay all appropriate claims for services provided to you or Your Dependents during the 1st month of the grace period;
2. Deny all appropriate claims for services provided to you and Your Dependents during the 2nd and 3rd months of the grace period.
3. Notify the Provider of service that claims are denied due to the status of the grace period, and they are eligible for reconsideration once the grace period is lifted; and 4. Notify the Exchange that you have not paid your Premium.

Retroactive denials:

A claim may be denied retroactively when:

A. Prior authorization for a service is required but there has been no request for review (prior authorization) to determine medical necessity
B. Services have been provided, and the member is no longer covered under the plan
C. Services have been provided and there has been no additional information submitted to AultCare for medical review to support that the continued services are medical necessary.

D. Services have been provided and the benefit has been exhausted

Ways to prevent retroactive denials:

A. Ensure that your provider has submitted appropriate clinical information for services that require prior authorization and be sure that the service is approved before receiving it.
B. Be sure that premiums are paid on time and that you meet eligibility requirements such as being in your area of residence for the required time.
C. If you are continuing to receive care for which prior authorization as required, be sure that your provider keeps AultCare informed of your progress and any needs for continued services.
D. Be sure to know your benefits and do not use them without being sure that they are necessary.

Enrollee recoupment of overpayments:

To request a refund due to overpayment of insurance premium by phone, please call AultCare Customer Service Center at 330-363-6360 (TTY: 711) or 800-344-8858. To request a refund due to overpayment of insurance premium by mail, please write to: AultCare Insured Customer Service, PO box 6910, Canton OH 44706-0910. Include your name, policy number and requested amount to be refunded with your correspondence.

Medical necessity and prior authorization timeframes and enrollee responsibilities:

MEDICALLY NECESSARY means Services or supplies provided by a Hospital, Doctor or other Provider to identify or treat an illness or injury, when those Services or supplies are determined to be:

A. Consistent with the symptoms or diagnosis and treatment of the condition, disease, ailment or injury.
B. Appropriate with regard to the standards of good medical practice.
C. Not primarily for the convenience of the patient, the Doctor or other Provider.
D. The most appropriate supplies or Services that can be provided safely to the patient. For an Inpatient, it means that the patient's symptoms or condition requires that the Services or supplies cannot be provided safely on an Outpatient basis.

Pre-Approval

Pre-Approval (also called “Pre-Certification” or “Pre-Authorization”) is an evaluation of your medical case by Your
Provider and AultCare medical professionals to determine the appropriateness of Your Hospital admission and expected length of stay. It means You or Your Network Provider must notify UM before You may receive certain Services, such as an elective Hospital stay, Transplants, and other Outpatient and Provider Services. Certain Referrals by Providers may require Pre-Approval. Pre-Approval is needed to help determine if other appropriate medical care possibilities have been explored and are within acceptable time elements. Certain services require pre-approval. If an AultCare Network provider has not obtained pre-approval, the service will not be paid, but the enrollee is held harmless. If the service is provided by an out of network provider, the service will be paid at the non-network level of benefit and the provider will be educated about the pre-approval process. The enrollee may always appeal the out of network level of benefit

Responses are made according to the following time lines:

• Urgent care: not later than 48 hours of receipt of the request.

- Non-urgent, pre-service: within 10 business days of receipt of the request.
- Post-service: within 30 calendar days of receipt of the request.
- Requests to extend treatment of urgent care: within 24 hours of the request. Prior-Approval is not required for treatment of Emergency Medical Conditions.

For a complete list of services requiring Pre-Approval, please contact AultCare at 330-363-6360 or 1-800-344-8858.

Drug exceptions timeframes and enrollee responsibilities:

Non-Formulary Medications

AultCare Health plans have a managed prescription drug formulary. That means we have a certain list of prescription drugs that we cover. If a drug is not on our formulary we will not pay for the drug. Please see the list of drugs included on the AultCare Marketplace formulary.

An exception request for coverage of non-formulary drugs can be made by the member, a designated representative, the prescribing physician or other prescriber. Requests can be made in writing, electronically, telephonically and faxed. To request a non-formulary drug, you may have your physician send an exception enrollment form to our pharmacy authorization department at AultCare, Attention: Pharmacy Department, P.O. Box 6910, Canton, Ohio 44706 or call us at 330-363-6360 (TTY: 711) or 1-800-344-8858. Fax 330-363-3284 Responses are made according to the following time lines:

Internal Exceptions Request Review:

• Urgent (Exigent) request: not later than 24 hours of receipt of the request.

- Exceptions based on urgent (exigent) circumstances are approved for coverage of the non-formulary drug for the duration of the prescription, including refills.

• Non-urgent (Standard) request: not later than 72 hours of receipt of the request.

- Exceptions based on non-urgent (standard) request are approved for coverage of the non-formulary drug for the duration of the prescription, including refills.

External Exception Request Review:

If we deny a non-urgent (standard) or urgent (exigent) request, we have a process in place to allow the request to be reviewed by an independent review organization. Notification of a decision on an external exception request will be given to the member, representative, or physician no later than 72 hours following receipt of the request if the original request was a non-urgent (standard) request. If the original request was an urgent (exigent) request notification will be given no later than 24 hours following receipt of the request. If an external exception request is approved, we will provide coverage for the non-formulary drug for the duration of the prescription.

Contact our AultCare Service Center at 330-363-6360 (TTY: 711) or 1-800-344-8858 if you would like to request an exception of a Non-Formulary medication. You may also find this information on the website at www.aultcare.com.

Information on Explanation of Benefits (EOB):

AultCare processes an Explanation of Benefits (sometimes called an "EOB") that describes how we handled Your Claim. An EOB is not a bill, Your Provider may send you a bill, if needed. You may visit our website at www.aultcare.com to view your EOB online, or, you may request a paper copy via mail. The EOB describes the Group Number and the ID Number of the person who received Services, what

Services were provided, who provided them, and the date they were provided, any adjustments to show Cost Share, additional fee adjustments or Exclusions that You may or may not be required to pay, the total amount AultCare paid on the Claim and the date it paid, and the amount, if any, you are responsible for paying. The EOB is generated at the time the payment decision is made and the claim is finalized.

Coordination of Benefits (COB):

COORDINATION OF BENEFITS means the procedure used to pay health care expenses when a person is covered by more than one Plan. AultCare follows rules established by Ohio law to decide which Plan pays first and how much the other Plan must pay. This is to make sure the combined payments of all Plans are no more than your actual bills. The Coordination of Benefits ("COB") provision applies when a person has health care Coverage under more than one Plan The order of Benefit determination rules govern the order in which each **Plan** will pay a Claim for Benefits. The **Plan** that pays first is called the **Primary Plan**. The **Primary Plan** must pay Benefits in accordance with its policy terms without regard to the possibility that another **Plan** may cover some expenses. The **Plan** that pays after the **Primary Plan** is the **Secondary Plan**. The **Secondary Plan** may reduce the Benefits it pays so that payments from all **Plans** do not exceed 100% of the total **Allowable Expense**.

Issuer contact information:

If you have a question, problem, or Complaint, please call the AultCare Service Center. Our hours are 7:30 a.m. to 5:00 p.m., Monday through Friday.
If you live in Stark County, call 330-363-6360 (TTY: 711). You also may call our toll-free number 1-800-344-8858.
You can email us at www.aultcare.com. Click on "Contact Us." We will direct your question to the proper person to answer. We will attempt to respond promptly, but that may not be the same day in which you emailed us. If you have a question that needs immediate attention, please call us.
You can fax us at 330-363-9804. You can write us at:
AultCare Service Center
P.O. Box 6910
Canton, Ohio 44706
If you write, please list Your Group Number, and AultCare ID Number in your letter. This information is on your AultCare card. If you call, please have your current AultCare card in front of you.
The address for the Ohio Department of Insurance is:
Ohio Department of Insurance
Consumer Services Division
Third Floor - Suite 300
50 W. Town Street
Columbus, OH 43215