P2797005002

AULTCARE
P. O. BOX 6910
CANTON, OH 44706-0910
330-363-6360

Explanation of Benefits
Enrollee Copy

For claim questions or general information:

Call: 330-363-6360 or 1-800-344-8858
Hearing impaired 330-363-2393 or 1-866-633-4752
Monday - Friday 7:30 a.m. to 5:00 p.m.

Email: aultcare@aultcare.com

Visit us: www.aultcare.com

Electronic Service Requested

SINGLE PIECE

1 0.7130 SP 0.440

Enrollee Name: 1
Address:
City: State: Zip:

Group #:
Group:
Date:
Member ID:

This is not a bill

Claim Payment Detail

Provider Name: Patient Name: Employee:
Claim#: Patient #:

Dates of Service -- CPT/Mod Procedure Description	Billed Amount	Ineligible Amount	Remark Code	Contractual Adjustment	Adj Code	Coin-Copay/ Deductible	Payment Amount	Other Payment
04/20-04/20/2011 PRESCRIPTION DRUGS	3.48	0.00		0.00		3.48	.00	0.00
04/20-04/20/2011 PRESCRIPTION DRUGS	13.31	0.00		0.00		10.00	.00	3.31
04/20-04/20/2011 PRESCRIPTION DRUGS	100.00	0.00		0.00		50.00	.00	50.00
04/20-04/20/2011 PRESCRIPTION DRUGS	177.21	0.00		0.00		88.61	.00	88.60
TOTALS	294.00	0.00		0.00		152.09	0.00	141.91

Total Net Payment: **141.91**

Messages

WE HAVE A NEW LOOK! PLEASE GO TO THE AULTCARE WEBSITE FOR A MORE DETAILED EXPLANATION.

Note: If check is being issued, it will be included with your explanation of benefits.

AULTCARE
P. O. BOX 6910
CANTON, OH 44706-0910
330-363-6360

FIRSTMERIT BANK N.A.
56-55/412

CHECK NO.

ISSUE DATE

AMOUNT
***$141.91

PAY ****ONE HUNDRED FORTY-ONE DOLLARS AND 91 CENTS****

VOID AFTER 90 DAYS

TO THE ORDER OF

VOID

Authorized Signature

P2797005002

Notification of right to appeal.

If claim for benefit was denied, the following are details of the determination:

There may be multiple reasons why your claim was denied. Please reference the preceding explanation of benefit pages to determine the cause for denial. Your explanation of benefit will provide you with any applicable denial codes and corresponding meanings. If your denial was based on a specific plan provision, please contact your Plan Administrator.

If the claim was not a clean claim, a description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary will be provided free of charge upon request.

If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination and/or applying the terms of the plan to the claimant's medical circumstances will be provided free of charge upon request.

The diagnosis code(s) and treatment code(s) relating to this claim, along with an explanation of each, are available upon request.

FIRST LEVEL APPEAL

Written notice is provided if your claim for benefits is denied. Your provider may request a reconsideration of this decision. You and/or your provider may request the clinical rationale used by us to reach this decision. You may also request an internal review of our decision (with or without first requesting a reconsideration) by submitting a written appeal within 180 days of our notice of denial or you will lose your right to appeal. If you do not appeal within the 180 days allotted, you will also lose your right to file suit in court as you will have failed to exhaust your internal appeal rights, which is generally a prerequisite to bringing suit. Your appeal should state the reasons you feel your claim should not have been denied. You should include any additional facts and/or documents in support of your claim. You may also ask additional questions and make written comments, and you may review (on request and at no charge) documents and other information maintained by us that are relevant to your appeal. The individual deciding your appeal will conduct a full and fair review of the initial decision and will review all written comments you submit for your appeal. To the extent required by applicable law, we will consider your appeal according to the following timeframes:

- Urgent Pre-service request - You will be notified of our decision as soon as possible, taking into account the medical condition, but not later than 72 hours of our receipt of your appeal.
- Pre-service request - You will be notified of our decision within 15 days of our receipt of your appeal.
- Post-service claim - You will be notified of our decision within 30 days of our receipt of your appeal.
- Concurrent claim - You will be notified of our decision prior to termination of the benefit.

An **expedited/urgent review** will be conducted if your physician or provider certifies that your condition could, in the absence of immediate medical treatment, result in any of 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.

You will receive a written explanation of our decision and your rights to further review. You may also be entitled to an external review if certain requirements are met, such as when the Plan waives the exhaustion of internal appeals requirement.

P2797005002

SECOND LEVEL APPEAL

The following second level appeal process applies to all enrollees. If we continue to deny the payment, coverage, or service requested, you will have access to a second level appeal. You must request your second level appeal within 180 calendar days of receipt of our first level appeal decision. Your second level appeal will be conducted by your Plan Administrator who will conduct a full and fair review of the initial decision and first level appeal decision. The Plan Administrator may secure independent medical advice or other information and require such evidence as it seems necessary to decide your appeal. You will be notified of the decision in writing. The decision will set forth: 1) the specific reason for the denial; 2) the specific Plan provision(s) on which the denial is based; 3) a statement of your right to review (on request and at no charge) relevant documents and other information; 4) any internal rule, guideline, protocol, or similar criterion the Plan Administrator relied on, upon your request to receive this information; 5) a statement of your right to bring suit under ERISA § 502(a); and 6) scientific or clinical guidelines used if the decision was based on medical necessity or experimental treatment, upon your request to receive this information free of charge. For a detailed explanation of your rights, please consult your Benefit Booklet. Your second level appeal will be decided in the same timeframe as your first level appeal.

The following second level appeal process applies only to enrollees covered under Public Employer Group Plans. If we denied your request because the service is not covered under the terms of your plan, you may, within 60 days of receipt of the internal review decision, appeal to the Superintendent of the Ohio Department of Insurance (ODI) at the Consumer Services Division, 50 West Town St., Third Floor, Suite 300, Columbus, Ohio 43215. ODI will review your plan and the service requested and provide you with a decision as to whether the service is covered.

EXTERNAL REVIEW (If you are entitled under your plan.)

If after the second level of internal appeal, we continue to deny the payment, coverage, or service requested, you may request an external review. Such request for external review must be received within 4 months of receipt of a final notice of denial from the internal claims and appeals process. Within 5 business days of the date of receipt of your request, a preliminary review will be conducted to determine whether you are eligible for an external review by determining (i) whether you were covered under your plan at the time the health care item or service was requested or provided; (ii) whether the adverse determination was related to your failure to meet the requirements for eligibility or involved a medical judgment or rescission of coverage; (iii) whether you have exhausted internal appeals where required; and (iv) whether you have provided all information required for an external review. If eligible, an independent review organization (IRO) will be assigned to conduct the external review. The IRO will contact you within 10 business days following the date of receipt of your request for review. You will have 10 business days to provide any additional information you would like the IRO to consider. The IRO must provide written notice of the final external review decision within 45 days after it receives a request for review, or 72 hours for an expedited external review. See the above criteria for expedited/urgent review. The IRO is not connected in any way with us. You are not responsible for the cost of the IRO.

Send all appeals, requests for review, and requests for clinical rationale to: P.O. Box 6029, Canton, Ohio 44706-0910.

If you have any questions about the appeals process, please contact our Customer Service Center, the phone number is listed on the front of the explanation of benefit pages. For questions about your rights, this notice, or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

To report fraud, waste, or abuse call 1-800-204-5119