



Welcome to



At AulCare, You Matter!

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

We are here for you!

Self-Funded
Administration Manual





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1 | Contact Information

Sales and Retention Department

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

Phone | 330-363-6390

Fax | 330-363-7724

Service Center

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

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

Fax | 330-438-9804

Online Chat at [AultCare.com](https://www.aultcare.com)

Billing Department

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

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

Fax | 330-363-5012

Email | aultcarebilling@aultcare.com

Member Services/Eligibility Department

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

Phone | 330-363-6360

Fax | 330-363-7746

Email | aultcareeligibility@aultcare.com

Visit our website

[AultCare.com](https://www.aultcare.com)

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

Employer Account Registration Guide

Welcome

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

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

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

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

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

Thank you,

Your AultCare Team

Employer Portal Access



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

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

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

4 | Enrollment Forms

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

1. Step-By-Step Guide

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

2. Enrollment Application

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

3. Cancellation and Continuation Form

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

4. Important Information

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

Do not make enrollment changes on your monthly premium invoice.

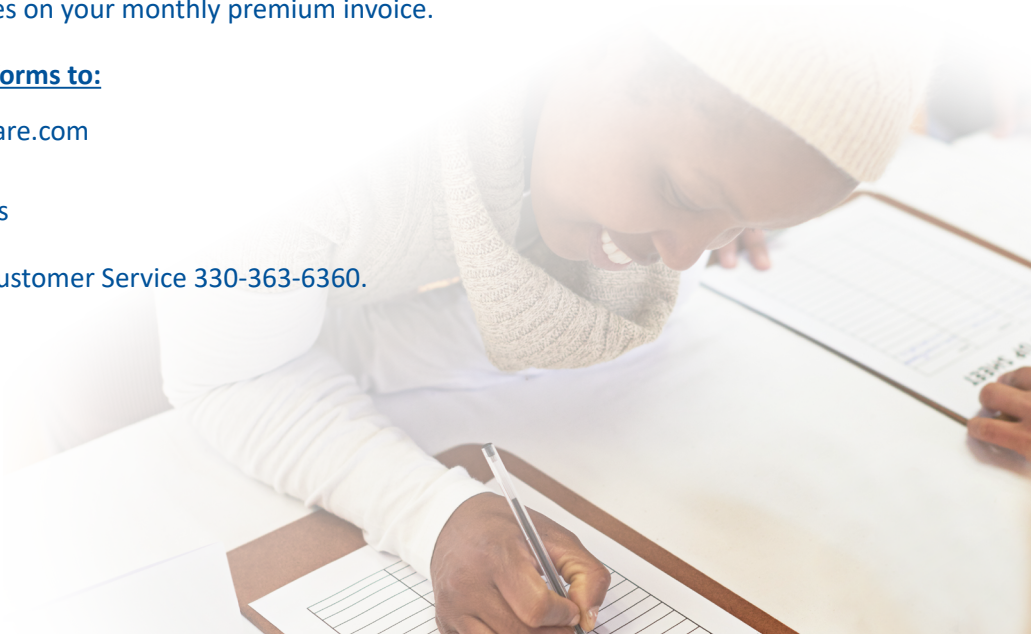
Return completed enrollment forms to:

Email: aultcareeligibility@aultcare.com

Fax: 330-363-7746

Mail: AultCare Member Services

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



Guide for Completing the Enrollment Application/Change Form

Please complete this form in its entirety.

EMPLOYER USE ONLY

This section is to be completed by the employer representative.

Employer Group Numbers

List all AultCare group numbers that apply. (Medical, Dental, Vision)

Employee Location/Job Classification

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

Leased Network

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

AultCare Effective Date

Provide the date the coverage is set to begin.

OTHER COVERAGE INFORMATION

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

MEDICARE INFORMATION

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

OTHER INFORMATION

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

EMPLOYEE COVERAGE ELECTION

This section is to be completed by the employee.

A) NEW POLICY APPLICATION

☐ New Group ☐ New Hire ☐ Open Enrollment
☐ Waiving Coverage

Designate the reason for applying for coverage or if coverage is being waived. If waiving coverage, a signature is required on the back of this form.

☐ Qualifying Event – Explain:

If applying for coverage for a qualifying event, please provide a detailed explanation. (For example: spouse lost coverage, marriage, birth, adoption.)

Hire Date

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

Coverage Type(s) Requested:

Check All that Apply ☐ Medical ☐ Dental ☐ Rx
☐ Vision ☐ STD ☐ Life ☐ Flex ☐ HSA ☐ HRA

Be sure to check all benefit options being elected.

Plan Requested: Plan Name

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

ADDITIONAL COVERAGE FOR DEPENDENTS

This section is to be completed by the employee.

A(dd), C(hange), D(elete)

Please provide the reason code for enrolling or disenrolling dependents.

Social Security Number

SSN are required for all dependents with coverage.

Benefits Selected (M,D,V,R)

List all that apply.

Other Insurance Coverage? (Y/N)

If yes, please complete the other coverage information on the back of this form.

All Employees

Signature _____ Date _____

Employee must sign and date when electing coverage.

Employees Waiving Coverage

Reason for waiver of coverage: _____

Employee and spouse must provide reason for waiving coverage.

Signature _____ Date _____

Employee and spouse must sign if either are waiving coverage.

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

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

Employer to send completed form to AultCare by one of the following methods.



AULTCARE USE ONLY		EMPLOYER USE ONLY		
Date Completed	Completed By	Employer Name	Employer Group Numbers	
Card Sent		Employee Location/ Job Classification	Leased Network ☐ Yes ☐ No	AultCare Effective Date

EMPLOYEE COVERAGE ELECTION	A) NEW POLICY APPLICATION ☐ New Group ☐ New Hire ☐ Open Enrollment ☐ Waiving Coverage ☐ You Only ☐ You & Your Spouse ☐ You & Your Child(ren) ☐ You, Your Spouse & Your Child(ren) ☐ Qualifying Event – Explain: _____					Date of Qualifying Event _____ (Qualified enrollment must be made within 31 days of event)	
	B) EMPLOYEE INFORMATION	Last Name		First Name		Middle Initial	Suffix
	Sex ☐ Male ☐ Female	Date of Birth		Social Security Number			
	Home Address (Number & Street)		County	City	State	Zip Code	
	Preferred Phone Number	Email Address					
	Marital Status ☐ Married – Date of Marriage _____			☐ Single ☐ Widowed ☐ Divorced ☐ Separated			
	Employment Status ☐ Full Time ☐ Part-Time ☐ Retired ☐ COBRA	Currently on Hire Date	Hours Worked Per Week	Are you currently actively at work? ☐ Yes ☐ No If not, why? _____			
	Coverage Type(s) Requested: Check All that Apply ☐ Medical ☐ Dental ☐ Rx ☐ Vision ☐ STD ☐ Life ☐ Flex ☐ HSA ☐ HRA				Plan Requested: Plan Name _____		

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

OTHER COVERAGE INFORMATION	Upon your effective date with this plan, will you or any of your family members have other health insurance? ☐ YES ☐ NO
	If yes, what is the name of the other insurance company?
	If yes, what type(s) of other health insurance will you have? Check all that apply ☐ Medical ☐ Dental ☐ Rx ☐ Vision

MEDICARE INFORMATION	Do you or your spouse or any enrolled dependents have Medicare coverage? ☐ YES ☐ NO If yes, please provide information below.			
	Medicare Enrollee Name	Medicare ID Number	Hospital Effective Date (Part A)	Medical Effective Date (Part B)
	Do you have Medicare Part D coverage? ☐ YES ☐ NO	If yes, what is the effective date of your coverage?		

OTHER INFORMATION	Do you, or any of your dependents, have any cultural or linguistic needs? ☐ YES ☐ NO		
	If yes, what are they?		
	Ethnicity: ☐ Non-Hispanic/Latino ☐ Hispanic/Latino ☐ Choose not to answer	Race: ☐ White ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Choose not to answer	Language: ☐ English ☐ Spanish ☐ Other _____

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

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

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

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

All Employees

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

Signature _____ Date _____

Employees Waiving Coverage

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

Reason for waiver of coverage: _____

Signature _____ Spouse Signature _____ Date _____

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

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

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



Cancellation/Continuation Notification

Today's Date:	Employer:
Group Numbers:	Completed By:

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

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

TRANSACTION CODES	
Cancellation of Coverage: A. Cancellation – Left Employment/Termination (Include in Comments section Termination Date & if Voluntary, Involuntary or due to Gross Misconduct) B. Cancellation – Deceased (Specify Date of Death in Comments section) C. Cancellation – Layoff (Include in Comments section the Date of Layoff & if Voluntary or Involuntary) D. Cancellation - Waiving (Specify in Comments if waiving coverage, include Enrollment Form with waiver section signed*.) E. Cancellation – Reduction in hours: no longer meets minimum eligibility requirements	Continuation of Coverage: F. COBRA Coverage Elected (Include Expiration Date, Copy of signed election form & proof of first payment) G. State Continuation of Coverage (For employers under 20 – please indicate expiration date of State Continuation of Coverage in the Comments section. Please include a signed Continuation of Coverage Election Form.) Other: H. Other (Include detailed explanation)

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

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

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

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

5 | *Open Enrollment FAQ*

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

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

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

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

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

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

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

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

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

Q. Will all members receive new ID cards?

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

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

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

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

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

6 | *HIPAA/Omnibus Rule and Self-Funded Group*

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

Special Enrollment Provision

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

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

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

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

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

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

All requests must include:

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

7 | *Employer Group Size Information*

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

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

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

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



8 | *Notices and Disclosures*

The following pages provide a checklist of the specific notices and disclosures under health care reform.

For each topic, we provide a citation to the statutory provision, a description of the notice or disclosure, effective date/timing of distribution and who is required to comply.

Disclaimer: This list is not legal advice and you should always seek the guidance of outside counsel if you have any questions about the legal obligations outlined within this document.



AultCare.com

Specific Participant Notices and Disclosures Under Health Care Reform

The following provides a checklist of the specific notices and disclosures under health care reform. For each topic, we provide a citation to the statutory provision, a description of the notice or disclosure, effective date/timing of distribution, and who is required to comply.

Citation to Statutory Provision	Description of Notice or Disclosure	Date/Timing	Required to Comply
Exchange Notice [FLSA§ 18B]	Information on Exchanges and the consequences if employee purchases a QHP through Exchange in lieu of employer-sponsored coverage	To new employees hired after October 1, 2013, within 14 days of their start date	Employers subject to FLSA
Patient protections [PHSA § 2719A]	Choice of primary care provider/ pediatrician (if plan requires or allows for this) and OB/GYN care without referral (if applicable, include in SPD or any description of benefits) (Notice of the right to designate any participating PCP; designate a pediatrician as PCP for any child and obtain OB/GYN care without PA or referral)	9/23/10	Group health plans and insurers (n/a to grandfathered plans or coverage)
Rescissions Prohibition [PHSA § 2712]	30 day advance notice of retroactive cancellation or discontinuance of coverage (permitted only in limited circumstances such as fraud or misrepresentation of a material fact upon event or on request)	After 9/23/10	Group health plans and insurers
Information Reporting of Minimum Essential Coverage MEC (Insurers and Employers That Self- Insure) [Code § 6055]	Forms 1094-B directly to IRS and 1095-B to covered employee Written statement of health coverage provided	Generally, annually on or before 1/31 after calendar year in which coverage was provided	For Insurers, sponsors of self-insured plans, and other entities providing "minimum essential coverage"
Information Reporting of Employer-Sponsored Coverage (Applicable Large Employers ALE) [Code § 6056]	Forms 1094-C directly to IRS and 1095-C to the covered employee Written statement of health coverage provided	Generally, annually on or before 1/31 after calendar year in which coverage was provided	Applicable large employers
Summary of Benefits and Coverage (SBC) & Glossary of Terms & Notice of Material Modifications to SBC {SMM} [PHSA § 2715]	SBC must meet certain appearance, language, and content requirements & 60-day advance notice required for material modifications not reflected in most recent summary	Distribution starting with first open enrollment beginning on or after 9/23/12; Exchange/FFM notice must occur within 14 days after start date	Group health plans and insurers

Group Health Plans: Federal Mandates Other Than COBRA & HIPAA

Mental Health Parity

- Under the MHPA/MHPAEA, cost-exemption notices notifying participants and beneficiaries of the plan's reliance on the increased cost exemption, including among other things, a statement regarding the availability upon request of a summary of the information on which the exemption was based (required only if plan claims exemption) Triggered only if plan claims the exemption from MHPAEA Provide upon event (must provide a 30 days advance notice to participants, beneficiaries and DOL) or on request
- Opt-out notices notifying enrollees of opt-out by self-funded non-federal governmental plan, annually and upon enrollment
- Employer Health Plans must provide a comparative analysis of the application of Non-Quantitative Treatment Limits (NQTs) to Mental Health/Substance Use benefits in comparison to Medical/Surgical benefits to ensure parity exists.

Women's Health and Cancer Rights Act (WHCRA)

- Enrollment notices notifying participants of WHCRA rights included upon initial enrollment, if not included in an SPD that is distributed upon initial enrollment
- Annual notices notifying participants of WHCRA rights, if not included in an SPD that is distributed annually
- Opt-out notices notifying enrollees of opt-out by self-funded non-federal governmental plan, annually and upon enrollment Plans

Newborns' and Mothers' Health Protection Act (NMHPA)

- Include in the SPD – Must describe, with respect to childbirth hospital stay for mother and newborn the applicable State or Federal requirements and the plan's coverage – use DOL model language
- Opt-out notices notifying enrollees of opt-out by self-funded non-federal governmental plan, annually and upon enrollment

Patient Protections Under Health Care Reform

- Written notice of the right to designate a primary care provider or pediatrician and to obtain obstetrical or gynecological care without preauthorization or referral must be provided not later than the first day of the first plan year beginning on or after September 23, 2010, and with SPD

Surprise Billing

- Employer Health Plans must provide to participants, in plain language, information regarding balance billing protections in both emergency and certain non-emergency situations. The information must be listed on the plan's website and on all EOBs.

Cost Transparency Rules

- Employer Health Plans must make available to members price comparison information. The information must be accessible in an internet-based self-service tool (or paper upon request). By January 1, 2023, plans must have price comparison information for 500 items and services as described in regulation. By January 1, 2024, all other items and services must be accessible through the internet tool.
- To support your compliance obligations, you may link to AultCare's MRFs at AultCare.com/pricetransparency from your publicly available website. We are sharing this link in advance to help you prepare.

Group Health Plans: Federal Mandates Other Than COBRA & HIPAA

Member ID Cards

- Must list the plan's deductible and out-of-pocket information, as well as, the plan's contact information.

Continuity of Care

- Employer Health Plans must continue to cover certain benefits on an in-network basis when a provider or facility ceases to be in-network. Will require COBRA-like provisions, with plan notifying enrollee of right to obtain this benefit and enrollee electing the benefit. Generally applicable for serious and complex (or terminal) medical conditions.

Provider Directory and Coverage Information Requests

- Employer Health Plans must create a database on a public website that includes a list of providers and facilities that are in-network. Information must be verified and updated every 90 days (to remove providers who have left network.) If information that plans provide about in-network status is incorrect, the plan enrollee may be protected from higher cost-sharing amounts.

Americans with Disabilities Act (ADA)

- EEOC notice of rights to be posted on employer's premises
- No specific notice requirements with respect to employer-sponsored group health plans, except for certain wellness programs - ADA Wellness Program Notice to be provided at initial enrollment and at annual enrollment (If wellness program includes an activity only or outcome based reward, SPD must include contact information and statement that an alternative standard is available and that recommendations of attending physician will be accommodated) EEOC has model notice

Genetic Information Nondiscrimination Act (GINA)

- Employers should include language in any lawful request for medical information specifically directing the individual or health care provider not to provide genetic information (EEOC model language is available)

Medicare Secondary Payer (MSP) Requirements

- Exemption notice: Multiemployer or multiple employer plans seeking small employer exception from age-based MSP rules must send letters to affected employees notifying them and their spouses that employer is exempted from the MSP rules
- Mandatory reporting rules: Although the mandatory reporting rule requirements require reporting to the government in certain situations, they do not appear to require any additional notices or reporting to plan participants (although required reporting entities (RREs) may need to use model language documents to collect information from plan participants in order to qualify for a reporting safe harbor)

Medicare Part D: Creditable Coverage Disclosure and Coordination of Benefits Requirements

- Disclosure notices (creditable coverage and non-creditable coverage disclosure notices) to be sent to Part D eligible individuals
- Provided at initial enrollment; annually by Oct. 15; upon certain events and on request
- For Group health plans with prescription drug coverage – CMS has model notices

HIPAA and COBRA

HIPAA	COBRA
• Include nondiscrimination disclosure in SPD ACA §1557 now requires the posting of a notice of nondiscrimination with translated taglines in other languages offering assistance. 1557 also prohibits discrimination based upon race, color, national origin, sex, age or disability in health program or activities receiving funding from HHS (includes Medicare, Medicaid, QHP/FFM, etc.) • Special enrollment notices to employees describing special enrollment rules and rights given at initial enrollment, on event or upon request. Can include in annual enrollment materials, too. Describe special enrollment rights in the SPD • CHIP notice at annual enrollment (consider special enrollment notice at annual as well) Annual notice describing possible premium assistance available in State in which employees reside Model notice found on DOL • Notice of privacy practices to individuals given at initial enrollment, on event (60 days after a material revision of the notice) or upon request. NPP has specific requirements as to its contents – use HHS model notice; Notice of availability of NPP given at least once every 3 years (can be given at annual enrollment each year) • Notice to employees regarding potential opportunities for State premium assistance subsidy (beginning in 2010) • Other HIPAA notices such as Breach notices, responses to individual rights to access own PHI, etc. apply as well, but are beyond the scope of this checklist	• Recommendation to send standalone notice to employee and spouse within initial notice time period • Initial notices to covered employee and covered spouse explaining COBRA rights and obligations generally in SPD – must include a general description of COBRA coverage and description of qualified beneficiary/covered employee's obligations; Provide within 90 days after individual's coverage commences • Description of COBRA rights and obligations found in SPD – statement of rights and obligations relating to continuation of coverage • Election notices to qualified beneficiaries who experience a qualifying event providing information about rights and obligations relating to a specific qualifying event or upon request; DOL has model notice; Provide within 14 days after receipt of qualifying event notice from employer or qualified beneficiary/covered employee. Or within 44 days after qualifying event for which the employer is responsible (term of employment, death) recommend send first class mail with documentation; Furnish to each qualifying beneficiary (single notice can go to employee and spouse at same address and serves as notice to dependent children) • Notice of unavailability of COBRA coverage to individuals who may expect to receive coverage on event or upon request • Notice of termination of COBRA coverage to affected qualified beneficiaries on event or upon request • Notice of conversion to affected qualified beneficiaries where plan provides conversion option • Notice of insignificant shortfall on event or upon request • Model notices for COBRA premium reduction subsidy • Other COBRA notices may apply as well, but are beyond the scope of this checklist

Required Participant Disclosures Other than in SPDs and SBCs

Qualified Medical Child Support Orders (QMCSOs)	Required Coverage for Dependent Children (Michelle's Law)
• QMCSO receipt letters notifying participant and each alternate recipient of the receipt of a QMCSO and of the plan's procedures for determining whether a medical support order is a QMCSO • QMCSO determination letters notifying participant and each alternate recipient as to whether an order has been determined to be a QMCSO • QMCSO procedures can be given, if requested by a participant or beneficiary and if not included in the plan's SPD (procedures typically included in SPD) • National Medical Support Notices (NMSNs). In addition to observing QMCSO requirements above, and completing the Employer/Plan Administrator Responses to Parts A and B in accordance with the NMSN instructions, the employee, child, and custodial parent must be notified that coverage will become available. If the NMSN is determined not to be appropriately completed, the employee, custodial parent, and alternate recipient must be notified.	• If coverage for a dependent child is conditioned upon the dependent's status as a student, any request for certification of student status must include a notice as to the provisions of Michelle's Law • Opt-out notices notifying enrollees of opt-out by self-funded non-federal governmental plan, annually and upon enrollment

ERISA

ERISA
• Summary Plan Description (SPD) – Includes eligibility, benefits and plan design • Statement of ERISA Rights (model language in DOL regs) SPD is provided within 90 days for new participants (120 for new plans) and at least every 5 years if any material changes (10 years if no changes) Provide to all covered participants (generally not beneficiaries) – also provide to surviving spouse, QMCSO recipient and COBRA qualified beneficiary. Provide by first class mail or hand deliver at the work place. Electronic delivery is permitted under certain rules. Document delivery method. • Summary of Material Modifications (SMM) – updates the SPD - upon event or at request SMM is provided when there is any material change or change to any required SPD content – provide within 60 days after material reduction in covered services or benefits or within 210 days after end of plan year in which the change is adopted • Summary of Benefits and Coverage (SBC) – written plan summary with prescribed format and content SBC provided with enrollment materials (60 day advance notice for midyear material modifications affecting SBC content) Can be paper or electronic (for online enrollment) Must go participants and beneficiaries • Summary Annual Report (SAR) (required if plan is (1) funded; or (2) insured with 100 or more participants at beginning of plan year) – Annually 9 months after PY ends or 2 months after Form 5500 extension; Is a summary of Form 5500 – for the participants – model language found on DOL. If plan does not file 5500, then no SAR is required • Responses to written participant requests for documents • Claims procedure notices – typically found in the SPD or in separate document distributed and referenced in the SPD • Offer of assistance in non-English language (taglines) • Other ERISA notices may apply as well, but are beyond the scope of this checklist

Requirements under the CAA Impacting Self-Funded Groups

Handled by AultCare TPA	Handled by Self-Funded Plan Sponsor
No Surprises Act (NSA)/Surprise Billing	
Independent Dispute Resolution (IDR)	
Notice of IDR Initiation	
Pharmacy Benefits and Drug Cost Reporting (RxDC) - Submission of Data	Pharmacy Benefits and Drug Cost Reporting (RxDC) - Provide Data to AultCare Annually
Continuity of Care	
Provider Directories	
Member ID Cards	
Balance Billing Disclosures	
Gag Clauses on Price & Quality Data	
Price Comparison Tool	
Mental Health Parity - NQTLs	Mental Health Parity - Quantitative Only
Broker Reporting - Group Markets	

No Surprises Act (NSA)/Surprise Billing - Bans surprise billing for emergency services, bans out of network cost sharing for emergency and non-emergency services at in network facilities, bans out of network charges for ancillary care at in network facilities, bans other out of network charges without advance notice.

Independent Dispute Resolution (IDR) - third party arbitration used in the event of failed negotiations between parties for payment of surprise bills (out of network services) after a 30 business day open negotiation period to reach an agreement on the out of network rate.

Notice of IDR Initiation - initiating party must furnish the Notice of IDR Initiation to the Departments by submitting a notice through the Federal IDR portal. The initiation date of the Federal IDR process will be the date of receipt of the Notice of IDR Initiation by the Departments. After notice is provided to the Departments, both parties will have no more than 3 business days to mutually agree on a certified IDR entity. If an agreement cannot be reached, the Departments will select a certified IDR entity through a random selection method.

Pharmacy Benefits and Drug Cost Reporting (RxDC) - requires each group health plan to report through HIOS certain information related to prescription drugs to the secretaries of the HHS, DOL, and Treasury. The required information to be submitted annually includes the plan year, number of enrollees, each state in which the plan is offered, the top 50 brand prescription drugs paid for by the plan, and the total number of paid claims for each drug, the top 50 most expensive prescription drugs paid for by the plan by total annual spending, and the annual amount

spent by the plan for each drug, the 50 prescription drugs with the greatest increase in plan expenditures since the prior plan year, and the change in amounts spent for each drug, the total spending on health care services by plan, broken down into specific categories, including hospital costs, primary care costs, specialty care costs, and prescription drug costs, the average monthly premiums paid by employers and by participants and the impact on premiums by rebates and fees paid by drug manufacturers to the plan or its administrators or service providers, including any reduction in premiums and out-of-pocket costs associated with the rebates and fees.

Annual reports are due by June 1 for the prior year's plan data. Each plan sponsor must provide the requested data for submission to be completed by Aultcare.

Continuity of Care - If a provider leaves the network, enrollees may have up to 90 days of care at in-network rates to make the transition if the member is being treated for a serious or complex medical condition, inpatient care, scheduled surgeries, pregnancy and terminal illnesses. The health plan or insurer is required to provide notice to the enrollee of the opportunity to continue care. The transitional period lasts 90 days from the date of the notice but will end earlier if the enrollee begins treatment with another provider.

Provider Directories - Plans must verify provider information every 90 days. If a provider does not respond, that provider must be removed from the directory. If a member relies on an incorrect directory, they must get in-network benefits.

Member ID Cards - Beginning on 1/1/2022, In and Out of Network Deductibles and MOOP must be printed on ID Cards in clear writing and must include a phone number and website where an individual can ask about network status. This applies to physical and electronic ID cards. Additional deductibles and out-of-pocket limits could be provided on a website accessible through a QR code or link on the ID card. There is no standardized layout required as long as the card is reasonably designed to include all the required information and the ID cards comply with accessibility standards for people with disabilities.

Balance Billing Disclosures - Plans must include disclosures with notice according to balance billing protections. For Group Health Plans and Health Insurance Issuers for plan years beginning on or after January 1, 2022: Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

- (1) The restrictions on balance billing in certain circumstances,
- (2) Any applicable state law protections against balance billing,
- (3) The requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and
- (4) Information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.

Plans and issuers may, but are not required to, use the model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review and complete it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will consider use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Gag Clauses on Price & Quality Data – plans may not agree to restrictions in provider network contracts that would prevent them from accessing cost and quality of care information and providing that information to participants. This includes provider-specific cost and quality of care data. The amendments also require group health plans to ensure they have access to specific claims data that shows the costs related to claims.

The amendments also require group health plans to ensure they have access to specific claims data that shows the costs related to claims. Although group health plans would be required to have access to this specific cost data, providers and provider networks would be allowed to prohibit plans and health insurers from publicly disclosing the information received. Plans would have to certify their compliance annually.

Price Comparison Tool – Requires a tool for members to price compare services among providers. Effective for plan year beginning on or after 1/1/2023, under the Transparency in Coverage Rule, health insurers and group health plans, including self-funded groups, must make available an online tool that is available to participants, beneficiaries and enrollees personalized, real-time, cost-share estimates for 500 shop-able covered services and items, including prescription drugs, with paper versions or information provided over the phone, available upon request.

For plan years beginning on or after 1/1/2024, plans and issuers must make price comparison information available for all covered items, services and drugs.

Self-funded plans, including level-funded plans, are responsible to confirm compliance with their TPA to ensure the TPA complies with making the price compare tool available to their members and remain liable for compliance with the final rules.

Mental Health Parity – Issuer must analyze their use of NQTL's to ensure MH/SUD benefits are being administered in parity with Med/Surg benefits. Plans will have to document and make an analysis available, upon request, to the secretaries of the U.S. Department of Health and Human Services (HHS), the DOL, and the U.S. Department of the Treasury. If a participant were to make a complaint, or the secretaries of the agencies suspect a violation, they would request a copy of the plan's analysis. The CAA directs the secretaries of the agencies to request an analysis from at least 20 group health plans per year.

Broker Reporting - Group Markets – Requires brokers and consultants to disclose to plan sponsors compensation for services paid of \$1,000 or more. The broker or consultant will be required to make certain disclosures to the plan fiduciary, including a description of the services provided and a description of all covered compensation (direct and indirect). Failure to do so will mean that the contract would not be deemed "reasonable" under ERISA.

Notice of Privacy Practices

Your Information. Your Rights. Our Responsibilities.

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

Introduction

The terms of this Notice of Privacy Practices apply to _____ (“the Plan”). The Plan will share protected health information of members as necessary to carry out treatment, payment, and health care operations as permitted by law.

The Plan is committed to protecting the information you share with us and our Third-Party Administrator, **Aultra Administrative Group Corporation (“Aultra”) or AultCare Corporation (“AultCare”)**. In most cases throughout this document, the word “we” pertains to _____ and our Third Party Administrator (even if the Third Party Administrator is not named as such. We are required by law to maintain the privacy of our members' Protected Health Information and to provide members with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all protected health information maintained by us. Copies of revised notices will be mailed to all members covered by the Plan and copies may be obtained by mailing a request to the Protected Health Information Plan at the address listed at the end of this Notice.

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

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

Not every use or disclosure of PHI, with or without a signed Authorization, is listed in this NPP. Uses or disclosures not specified in this NPP often require an Authorization.

Terms

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

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

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

Covered Entities. Covered Entities include health care providers (e.g. hospitals, doctors, nurses, nursing homes, home health agencies, durable medical equipment suppliers, other health care professionals and suppliers), and group

health plans. _____ is a group health plan covered entity.

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Rights

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

You may have additional privacy rights:

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

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

- You may ask to see or get a copy of your health and claims records and PHI kept in a designated record set. There are some restrictions.
- We will get you a paper copy or electronic version of your health and claims records, or give you a summary, usually within 30 days of your request. Our Third Party Administrator may charge reasonable, cost-based fees.

You may ask to correct your health and claims records:

- You may ask in writing to correct your health and claims records in a designated records set if you believe they are incorrect, inaccurate, or incomplete.
- Our Third Party Administrator may say “no” to your request, but they’ll tell you why in writing within 60 days.
- You will have an opportunity to appeal.

You may request confidential communications or communications by alternative means:

- You may ask for contact to be made to you about claims, premiums, EOBs, or other matters about your health plan and coverage in a specific way, such as home phone, office phone, or cell phone, or by alternate means, such as one an address different from your home or usual email address.
- Let us know if you do not want anyone to leave any voice mail message.

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

- You may ask in writing not to use or disclose certain health information for treatment, payment, or operations. We may honor your request if you pay for treatment in full out-of-pocket.
- While we will consider reasonable requests, we/our Third Party Administrator is not required to agree to your request. We may say “no” if restricting information could affect your care or if disclosure is required by law.

You may request a list (“Accounting”) of those to whom we’ve disclosed PHI/ePHI:

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

You may get a copy of this NPP:

- You may ask for a paper copy of this NPP at any time, even if you have agreed to receive this NPP electronically. We will provide you with a paper copy promptly.

You may choose someone to act for you:

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

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

- If you believe your privacy or your HIPAA rights have been violated, we urge you to contact your employer Human Resource Representative _____.
- We take all complaints very seriously. We will investigate and take appropriate action if needed.
- You also may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to : 200 Independence Avenue, S.W., Washington, D.C. 20201. You may also call 1-877-696-6775, or visit www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will never retaliate against you for filing a complaint, asking a question, or expressing a concern.

Communicating with You

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

Communicating with You:

We/our Third Party Administrator may communicate with you about claims, premiums, or other things regarding your health plan.

Communicating with Family or Others Involved In Your Care:

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

Minors and Emancipated Minors:

- We may disclose a minor's PHI/ePHI to the minor's parent(s) or guardian, unless there are legal or policy reasons not to do so.
- We will not disclose PHI/ePHI to the parent(s) or guardian of an emancipated minor. A minor is emancipated

if he/she: (1) does not live with his/her parent(s); (2) is not covered by parental health insurance; (3) is financially independent of parent(s); (4) is married; (5) has children; or (6) is in the military.

Deceased Enrollees:

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

Uses and Disclosures

This section describes how we/our Third Party Administrator typically uses or discloses your PHI/ePHI with and without an Authorization.

No Authorization Needed:

- We will create, receive, or access your PHI/ePHI, which we may use or disclose to other covered entities for treatment, payment, and health care operations, without the need for you to sign an Authorization.
- We will disclose PHI/ePHI needed to treat or authorize treatment. For example, a doctor or health facility involved in your care may request your PHI/ePHI to make treatment decisions covered by the Plan.
- We will use or disclose your PHI needed for payment. For example, we will use information about your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary, and to pre-authorize or certify services covered by your health plan.
- We may disclose PHI/ePHI to governmental or commercial health plans that may be obligated under coordination of benefit rules to process and pay your claims.
- We will use and disclose your PHI/ePHI as necessary or required by law to administer your plan and for our health care operations. For example, we may use or disclose PHI/ePHI for underwriting purposes. We will not use or disclose genetic information for underwriting purposes.
- We may disclose PHI/ePHI to business associates to perform covered services. It is not necessary for you to sign an Authorization for us to share PHI/ePHI with our business associates for covered services.
- We will use PHI/ePHI gathered from our online enrollment tools to complete certain applications for enrollment. The use of these tools is voluntary and alternate methods of enrollment may be available should you choose not to provide all of the requested information needed to complete the online enrollment.

Authorization Needed:

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

- We will not disclose psychotherapy notes without a signed Authorization unless required by law.
- We will not disclose Substance Use Disorder Records in civil, criminal, administrative, or legislative proceedings against you unless you provide written consent, or the use or disclosure is based on a court order and you or the holder of the record is provided notice and an opportunity to be heard, as provided in Part 2 of Title 42 of the Code of Federal Regulations. A court order authorizing use and disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.
- We will not release medical records if subpoenaed, unless you sign an Authorization, or the lawyers sign a qualified protective order, or if we receive a valid court or administrative order.

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

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

Wellness Programs:

- If you voluntarily choose to participate in a Wellness Program, you may be asked to answer questions on a health risk assessment (HRA) and/or undergo biometric screenings for risk factors,
- Wellness Programs may also provide educational health-related information or services that may include nutrition classes, weight loss and smoking cessation programs, onsite exercise facilities, and/or health coaching to help employees meet their health goals.

Use and Disclosure of Health Information Permitted or Required by Law
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We may use or disclose PHI/ePHI, without your Authorization, as required by law, including, but not limited to:

- Workers' Compensation
- Public health agencies
- FDA and OSHA
- Ohio Department of Insurance and other regulatory and licensing agencies
- Emergency and disaster
- Prevent threat of serious harm
- Proof of immunization

Breach Notification

- You have the right to notification if a breach of your PHI/ePHI occurs. We will promptly notify you by first-class mail, at your last known address, or by email (if you prefer) if we discover a breach of unsecured PHI/ePHI, which includes the unauthorized acquisition, access, use, or disclosure of your PHI/ePHI, unless we determine through a risk analysis that a low probability exists that the compromise of your PHI would cause you financial, reputational, or other harm.
- We will include in the breach notification a brief description of what happened, a description of the types of unsecured PHI involved, steps you should take to protect yourself from potential harm, a brief description of what we are doing to investigate the breach and mitigate any potential harm, as well as contact information for you to ask questions and learn additional information.

Changes to this NPP

This section describes how and when we may change NPP and how we will inform you of any material changes.

- We reserve the right to change this NPP at any time, which we may make effective for PHI/ePHI we already used or disclosed, and for any PHI/ePHI we may create, receive, use, or disclose in the future.
- We will make material amendments based on changes to the HIPAA laws.
- Copies of revised NPPs will be mailed to all enrollees covered by the plan, and copies may be obtained by mailing a request to:

EMPLOYER'S NAME: _____

EMPLOYER CONTACT: _____

EMPLOYER'S ADDRESS: _____

CITY / STATE / ZIP CODE: _____

TELEPHONE: _____

10 | *Monthly Invoices*

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

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

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

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

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

Please remit premium payment by:

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

Invoice Statement Glossary of Terms

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

ACCOUNT SUMMARY STATEMENT

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



Company: GROUP NAME Your group name will appear here.
Group Number: GROUP01 Your group number will appear here.
Invoice Number: ARIU000000000001 Each Account Summary Statement will have a unique Invoice Number.
Billing Period: 08/2018
Due Date: 08/01/2018

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

ACCOUNT SUMMARY

Previous Account Balance	\$7,182.40
Adjustment Total	\$0.00
Current Charge	\$2,191.25

Total Amount Due	\$9,373.65
-------------------------	-------------------

FOR CORRESPONDENCE

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

PLEASE SEND ALL OTHER CORRESPONDENCE TO:

PO BOX 6910
CANTON OH 44706-0910

MESSAGES

Thank you for choosing AultCare.

Please include coupon below with your monthly premium payment.

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

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

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

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



AULTCARE INSURANCE COMPANY
PO BOX 6910
CANTON OH 44706-0910

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

ACCOUNT NUMBER: AAIP000000000001

DUE DATE: 08/01/2018

TOTAL AMOUNT DUE: \$9,373.65

Please Remit Payment to:

GROUP NAME
123 S MAIN ST
CANTON OH 44720-3021



AULTCARE INSURANCE COMPANY
PO BOX 94603
CLEVELAND OH 44101



AAIP00000000000100809373657

134680-AULTCARE-1

ACCOUNT SUMMARY STATEMENT



Company: GROUP NAME
Group Number: GROUP01
Invoice Number: ARIU000000000002
Billing Period: 08/2018
Due Date: 08/01/2018

Statement Date: 07/15/2018

ACCOUNT SUMMARY

Previous Account Balance	\$2,365.50
Adjustment Total	-\$373.10
Current Charge	\$709.65

Total Amount Due \$2,702.05

FOR CORRESPONDENCE

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

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CANTON OH 44706-0910

MESSAGES

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

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

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



AULTCARE INSURANCE COMPANY
PO BOX 6910
CANTON OH 44706-0910

ACCOUNT NUMBER: AAIP000000000002

DUE DATE: 08/01/2018

TOTAL AMOUNT DUE: \$2,702.05

Please Remit Payment to:

GROUP NAME
123 S MAIN ST
CANTON OH 44720-3021



AULTCARE INSURANCE COMPANY
PO BOX 94603
CLEVELAND OH 44101



AAIP00000000000200802702053

134680-AULTCARE-2

GROUP NAME:

GROUP NUMBER:

PERIOD:



GROUP NAME

GROUP01

08/2018

MEMBER NAME/ RATE CODE	COV TYPE	COBRA	LEASED NETWORK	PREMIUM/ ADMIN	NETWORK FEES	DENTAL	VISION	HRA/HSA/ FLEX	STOP LOSS	ANCILLARY	BROKER FEES	TOTAL FEES
BALANCE FORWARD:												\$9,547.90
RATE CODE 1												
BROWN, JIM	1			236.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$236.55
DELAMIELLEURE, JOE	1			236.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$236.55
GRAHAM, OTTO	1			236.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$236.55
RATE CODE 1 TOTAL				709.65	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$709.65
RATE CODE 2												
BROWN, PAUL	1			427.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$427.70
HICKERSON, GENE	1			427.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$427.70
LAVELLI, DANTE	2		RN35	898.15	10.00	0.00	0.00	0.00	0.00	0.00	0.00	\$908.15
MOTLEY, MARION	1			427.70	0.00	0.00	0.00	0.00	0.00	0.00	0.00	\$427.70
RATE CODE 2 TOTAL				2181.25	10.00	0.00	0.00	0.00	0.00	0.00	0.00	\$2,191.25
INVOICE TOTAL:												\$2,900.90
June 2018 Adjustments												
KOSAR, BERNIE	1			-236.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-\$236.55
												-\$236.55
July 2018 Adjustments												
KOSAR, BERNIE	1			-236.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-\$236.55
												-\$236.55
Manual Adjustments:												
COBRA PACKETS				0.00	0.00	0.00	0.00	0.00	0.00	100.00	0.00	\$100.00
												\$100.00
Total Adjustments:				-473.10	0.00	0.00	0.00	0.00	0.00	100.00	0.00	-\$373.10
GRAND TOTAL:												\$12,075.70
Coverage Type												
1 EMPLOYEE (INDIVIDUAL) ONLY												
2 EMPLOYEE AND SPOUSE												
Leased Network Description												
RN35 PRIVATE HEALTHCARE SYSTEMS												
Coverage Counts												
EMPLOYEE (INDIVIDUAL) ONLY 6												
EMPLOYEE AND SPOUSE 1												

PO BOX 6910 • CANTON OH 44706-0910

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



**Self Funded - Funding Arrangements
CLAIM PAYMENTS and ADMINISTRATIVE FEES**

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

CLAIM PAYMENT CHECK & EFT RUN: Select the preferred day of the week for the claim check run.

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

NOTIFICATION: AultCare will provide a claim report and invoice for the total dollar amount due for claims processed the day following the check run. Select only the **ONE** notification method immediately below.

☐ **E-Mail:** Provide email address and contact name below.

Email Address: _____

Contact Name: _____

☐ **Web Portal:** AultCare will post claim information to the employer portal at www.aultcare.com

FUNDING ARRANGEMENT: Benefit checks are released upon receipt of appropriate funding. Select and complete **ONE** payment option.

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

AultCare Account Information:

Account Number: 01038342153

Routing Code: 044115090

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

Your Account Information (*required*):

Bank Name: _____

Bank Contact & Phone Number: _____

Account Number: _____

Routing Code: _____

☐ Withdraw funds the day after closing is received

☐ Withdraw funds upon notification from company to benefitinvoice@aultcare.com

☐ Withdraw funds after ____ business days from closing (*no greater than 4 days*)

ADMINISTRATIVE FEE INVOICE – MONTHLY:

(Pay as billed, enrollment adjustments will be made to subsequent invoices)

PAYMENT ARRANGEMENT - Select and complete ONE option

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

AultCare Account Information:

Account Number: 01039702501

Routing Code: 044115090

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

Your Account Information (*required*):

Bank Name: _____

Bank Contact & Phone Number: _____

Account Number: _____

Routing Code: _____

Tax ID: _____

Note: Automatic withdrawal on the 1st of every month

Completed by: _____

Signature: _____

Date: _____

11 | *Group Reporting User Guide*

Monthly Reports

Each month, AultCare uploads standard reports to your Employer Portal, including data from your group's paid claim utilization and activity. A description of each report is provided.

AultCare provides plan performance measures in several key areas. These executive summary reports are provided and presented by your AultCare Account Management team at least twice per year.



AultCare.com

INTRODUCTION



Data Availability

The reports are built using medical and pharmacy claims data as well as membership, enrollment and provider information. Throughout the reports, you will find both paid amounts and utilization metrics. The paid amount is the amount paid to the provider by the health plan on a claim.

Reporting Dates

Most monthly reports are based on paid dates and show year to date values. Some reports show the previous months values along with the year to date. Reinsurance reports will be based on your reinsurance contract incurred and/or paid dates.

Medical Claims Category

This report utilizes AultCare methodologies to stratify claims into high level categories. This methodology classifies healthcare claims data into groupings of similar types of services and calculates utilization measures. The Medical Claims Category Report allows you to compare current month and year to date on a total and a paid per unique enrollee basis by service category.

Diagnosis and Medical Procedure Summary

The Diagnosis and Medical Procedure Summary report contains two separate reports. Each worksheet displays a summary of the medical claims grouped by the primary diagnosis or primary procedure code. The report contains number of enrollees, the total paid, the total volume, the paid per unit, and the paid per unique enrollee.

Eligibility Breakdown Summary Report

One important component to understanding your healthcare information is to understand your population. In the Eligibility Breakdown Report you will find your total population as well as the distribution of your population by relationship and reporting division.

Cost Per Employee by Benefit

This report summarizes the total paid amount by benefit by month displaying the cost per enrollee and the cost per employee on a monthly basis and a year to date basis. This is a good tool to use to see how your healthcare costs are changing throughout the year.

Specific Reinsurance Individual Summary

Specific Reinsurance is the form of excess risk coverage that provides protection against a high claim cost on any one individual. This is protection against abnormal severity of a single claimant rather than abnormal frequency of claims in total. Specific stop-loss is also known as individual stop-loss. The Specific Reinsurance Individual Summary reports on any member who has a paid amount greater than 50% of the contract's specific deductible reported on the terms of the stop loss contract. The report indicates the amount above the specific retention, amounts that have been reimbursed by the stop loss carrier and any outstanding or open amount.

Lag Report by Benefit

The Lag Report is usually requested for a client's accounting and audit purposes. This report shows two full years plus the current year of paid dates and analyzes historical claims information to determine the length of time lag between the date of service and the date a claim is paid.

IRSElig Report

This report provides an accounting of each member covered by month. The report is a useful tool which provides the information necessary for the annual ACA 1094/1095 reporting.



Plan Performance

Current Period Paid: 2024-01-01 to 2024-10-31

Current Period Incurred: All Incurred

Prior Period Paid: 2023-01-01 to 2023-12-31

Prior Period Incurred: All Incurred

Executive Summary

Current Period Paid: 2024-01-01 to 2024-10-31

Prior Period Paid: 2023-01-01 to 2023-12-31

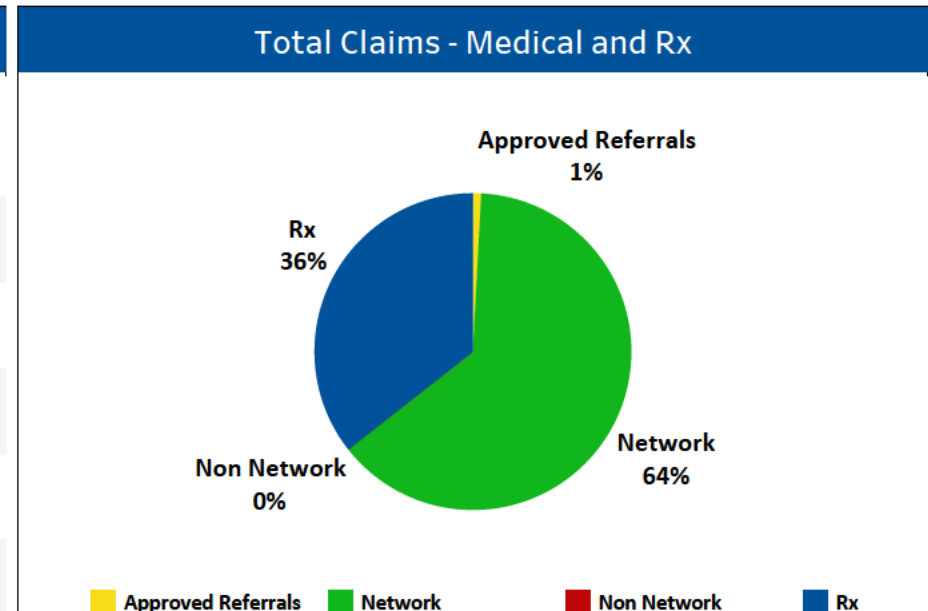
Avg Enrollment			
Current	Dependent	165	
	Employee	211	
	Spouse	59	
	Total	435	
Prior	Dependent	157	
	Employee	208	
	Spouse	62	
	Total	427	

Total Paid and PMPM				
AIC Avg PMPM	Current PMPM	Prior PMPM	Current Paid	Prior Paid
\$575.40	\$471.00	\$455.99	\$2,048,850.27	\$2,337,855.33

PMPM Category of Care			
	AIC Avg	Current	Prior
Ancillary	\$11.81	\$19.82	\$19.19
Inpatient	\$104.79	\$34.19	\$41.75
Outpatient Facility	\$213.23	\$162.70	\$203.05
Pharmacy	\$141.01	\$167.62	\$91.56
Physician	\$89.31	\$82.30	\$96.52
Post Acute	\$15.24	\$4.37	\$3.91

Top Facilities		
Provider Facility	Current	Prior
OPTUMRX PBM OF ILLINOIS INC	\$729,013	\$469,454
AULTMAN HOSPITAL	\$165,150	\$174,677
POMERENE HOSPITAL	\$146,293	\$288,066

Top Diags		
Diag Range Description	Current	Prior
Symptoms & Ill-Defined Conditions	\$839,010	\$592,800
Malignant Neoplasms	\$212,294	\$293,245
Skeleton & Muscle System	\$197,326	\$197,877



Executive Summary

Current Period Paid: 2024-01-01 to 2024-10-31

Prior Period Paid: 2023-01-01 to 2023-12-31

Top 5 Highest Paid Enrollees Current

Provider	Diagnosis	Termdate	Total
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		\$364,198
MASCI DO, PAUL	Multiple myeloma in relapse		\$98,363
AULTMAN INFUSION SERVICES	Other inflammatory and immune myopathies, not else	2024-07-31	\$89,134
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		\$89,110
GENESIS HEALTHCARE SYSTEM	Calculus of ureter	2024-08-31	\$79,174

Top 5 Drugs by Paid Current

Drug Name	Class	B/G/S	Paid	Vol	UEs
AYVAKIT	ANTINEOPLASTICS	Specialty	\$356,696	9	1
DUPIXENT	DERMATOLOGICALS	Specialty	\$89,596	23	3
COSENTYX SENSO	DERMATOLOGICALS	Specialty	\$85,485	12	1
SKYRIZI PEN	DERMATOLOGICALS	Specialty	\$59,686	3	1
HUMIRA PEN	ANALGESICS - ANTI-INFLAMMATORY	Specialty	\$30,185	5	1

Top Outpatient Hospitals Current

Provider Facility	Current
POMERENE HOSPITAL	\$134,024
WOOSTER COMMUNITY HOSPITAL	\$86,672
WOOSTER AMBULATORY SURGERY CENTER	\$75,046
AULTMAN HOSPITAL	\$71,687
GENESIS HEALTHCARE SYSTEM	\$66,253

Top Inpatient Hospitals Current

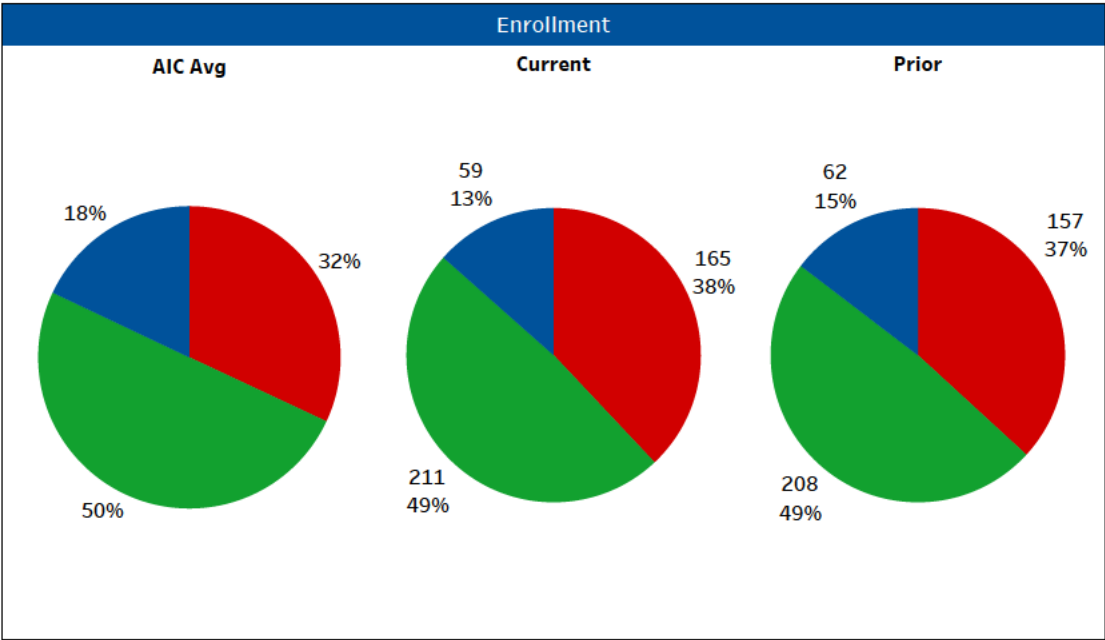
Provider Title	Paid	Days	Admits
WOOSTER COMMUNITY HOSPITAL	\$46,915	11	4
MERCY MEDICAL CENTER INC	\$39,220	3	1
AKRON CHILDRENS HOSPITAL	\$22,024	1	1
AULTMAN HOSPITAL	\$18,144	3	2
CRYSTAL CLINIC ORTHOPAEDIC CENTER LLC	\$11,841	1	1

Top 5 Outpatient Program Detail

Dashsubcat	Current		Prior	
	Paid	UEs	Paid	UEs
OR Services	\$155,201	30	\$239,251	48
ER LEVEL 3-5	\$130,817	50	\$106,301	74
Other Outpatient Facility	\$101,994	73	\$297,023	100
Surgery Center	\$80,483	14	\$23,452	9
Radiology	\$73,287	78	\$120,167	109

Top 5 IP DRG Detail

DRG Program	Current			Prior		
	Admits	Days	Paid	Admits	Days	Paid
Cardiac Services	1	3	\$39,220			
General Surgery	2	2	\$33,865			
General Medicine	4	6	\$28,725	3	8	\$12,016
Obstetrics	2	4	\$24,325	3	8	\$56,909
Neonatology	2	7	\$22,589	1	3	\$2,028



Relationship
Dependent Employee Spouse

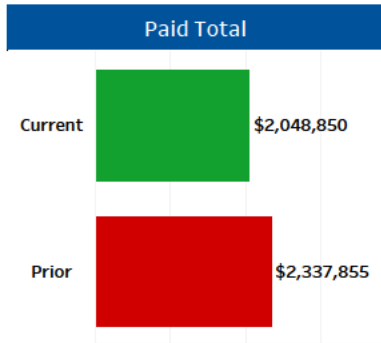
Total Average Enrollment	
Current	Prior
435	427

Leased Enrollment			
Current	Employee	Prior	Employee
31	14	14	8

Enrollment by Plan			
Plan_descr	Time Frame	Relationship	
SFPE	Current	Dependent	165
		Employee	211
		Spouse	59
	Prior	Dependent	159
		Employee	208
		Spouse	62
	Prior	Dependent	156
		Employee	207
		Spouse	62

Total Paid and PMPM

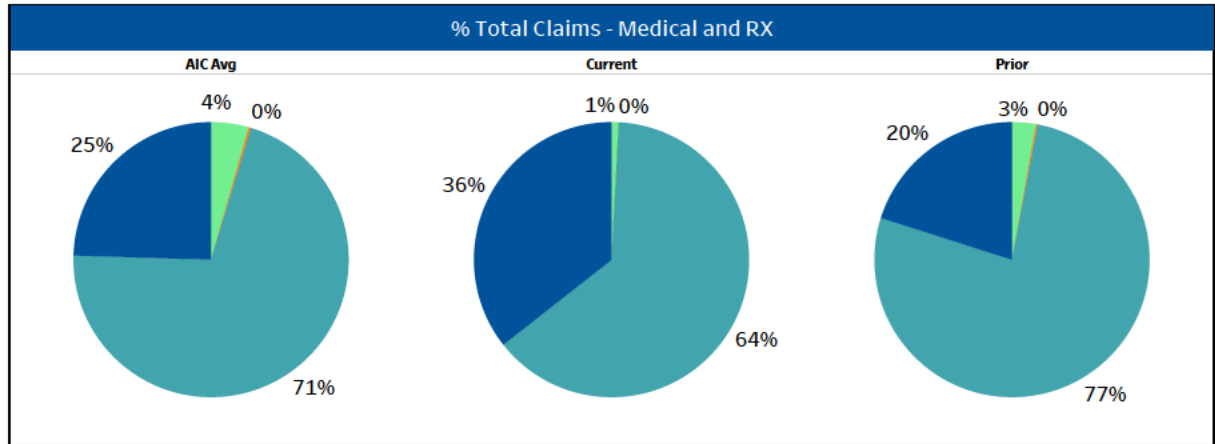
Current Period Incurred: All Incurred
 Current Period Paid: 2024-01-01 to 2024-10-31
 Prior Period Incurred: All Incurred
 Prior Period Paid: 2023-01-01 to 2023-12-31



PEPM (Total)		
AIC Avg	Current	Prior
\$1,148.68	\$970.10	\$938.90

PMPM Breakdown				
Employee	AIC Avg	Current	Prior	PMPM % Difference
Employee	\$336.35	\$319.06	\$305.83	4.32%
Spouse	\$139.90	\$94.07	\$103.97	-9.53%
Dependent	\$99.14	\$57.88	\$46.18	25.33%
Total	\$575.40	\$471.00	\$455.99	3.29%

PMPM Category of Care				
Ancillary	AIC Avg	\$11.81		
	Current	\$19.82		
	Prior	\$19.19		
Inpatient	AIC Avg	\$104.79		
	Current	\$34.19		
	Prior	\$41.75		
Outpatient Facility	AIC Avg	\$213.23		
	Current	\$162.70		
	Prior	\$203.05		
Pharmacy	AIC Avg	\$141.01		
	Current	\$167.62		
	Prior	\$91.56		
Physician	AIC Avg	\$89.31		
	Current	\$82.30		
	Prior	\$96.52		
Post Acute	AIC Avg	\$15.24		
	Current	\$4.37		
	Prior	\$3.91		



Panel
 Approved Referrals Non Network Network Rx

Primary Care Physician Utilization					
	Vol	UEs	Paid per Visit	Paid	PMPM
Current	1,050	293	\$81.39	\$85,457	\$19.65
Prior	1,206	307	\$129.08	\$155,675	\$30.36

Telemedicine Utilization				
	Vol	UEs	Paid per Visit	Paid
Current Telehealth	62	25	\$68.29	\$4,234
Prior Telehealth	67	34	\$51.19	\$3,430

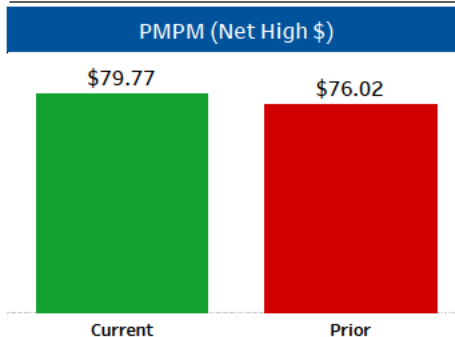
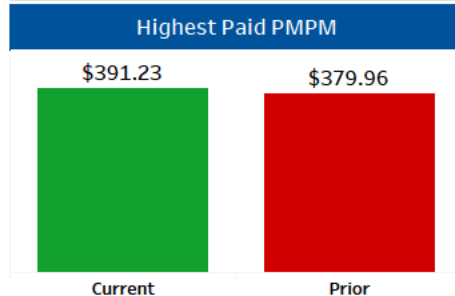
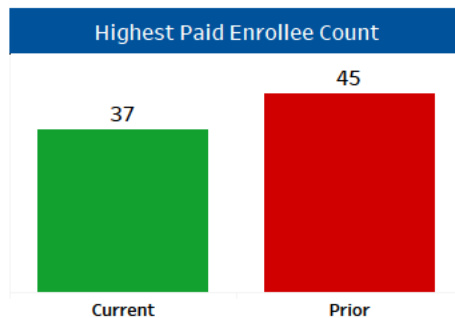
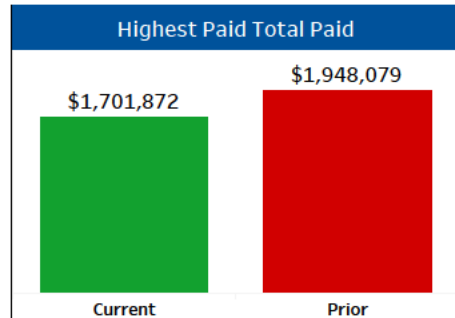
Total Paid and PMPM



Highest Paid Enrollees

Threshold: \$10,000

Current Period Incurred: All Incurred
Current Period Paid: 2024-01-01 to 2024-10-31
Prior Period Incurred: All Incurred
Prior Period Paid: 2023-01-01 to 2023-12-31



Top 10 Highest Paid Enrollees Current						
Provider	Diagnosis	Termdate	Rank	Medical	Rx	Total
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		10	\$3,142	\$361,056	\$364,198
MASCI DO, PAUL	Multiple myeloma in relapse		4	\$97,270	\$1,093	\$98,363
AULTMAN INFUSION SERVICES	Other inflammatory and immune myopathies, not else	2024-07-31	2	\$76,713	\$12,421	\$89,134
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		6	\$3,059	\$86,052	\$89,110
GENESIS HEALTHCARE SYSTEM	Calculus of ureter	2024-08-31	New	\$69,198	\$9,976	\$79,174
AKRON CHILDRENS HOSPITAL	Postprocedural hemorrhage of a respiratory system		New	\$56,552	\$18,631	\$75,183
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		8	\$70	\$59,713	\$59,783
AULTMAN ORRVILLE HOSPITAL	Unilateral primary osteoarthritis, right hip		New	\$54,207	\$79	\$54,287
WOOSTER COMMUNITY HOSPITAL	Nonrheumatic aortic (valve) stenosis		New	\$43,119	\$8,987	\$52,107
AULTMAN HOSPITAL	MALGNT NEOPLASM OF BILATERL OVARIES		New	\$50,218	\$275	\$50,493

Top 10 Highest Paid Enrollees Prior					
Provider	Diagnosis	Termdate	Medical	Rx	Total
WAYNE COUNTY KIDNEY CENTER	End stage renal disease	2023-09-25	\$173,197	\$2,641	\$175,838
AULTMAN INFUSION SERVICES	Other inflammatory and immune myopathies, not else	2024-07-31	\$128,383	\$25,666	\$154,049
ARTHUR G JAMES CANCER HOSPITAL AND RESEARCH INSTL.	Malignant neoplasm of thyroid gland		\$130,777	\$336	\$131,113
MASCI DO, PAUL	Multiple myeloma in relapse		\$122,144	\$1,013	\$123,157
SHEPPARD MD, CHRISTOPHER	Multiple sclerosis		\$107,966	\$635	\$108,601
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		\$5,237	\$94,407	\$99,644
OHIO STATE UNIVERSITY HOSPITAL	Longstanding persistent Afib		\$82,252	\$6,978	\$89,231
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		\$152	\$85,013	\$85,165
AULTMAN HOSPITAL	Meningitis, unspecified	2023-01-28	\$77,366	\$0	\$77,366
OPTUMRX PBM OF ILLINOIS INC	OTHER ILL DEF COND		\$18,633	\$46,638	\$65,271

Highest Paid Enrollees



Inpatient Dashboard and Outpatient Dashboard



Current Period Incurred: All Incurred
Current Period Paid: 2024-01-01 to 2024-10-31
Prior Period Incurred: All Incurred
Prior Period Paid: 2023-01-01 to 2023-12-31

Top Inpatient Hospitals				
Title	Panel	Paid	Days	Admits
WOOSTER COMMUNITY HOSPITAL	Network	\$46,915	11	4
MERCY MEDICAL CENTER INC	Network	\$39,220	3	1
AKRON CHILDRENS HOSPITAL	Network	\$22,024	1	1
AULTMAN HOSPITAL	Network	\$18,144	3	2
CRYSTAL CLINIC ORTHOPAEDIC CENTER LLC	Network	\$11,841	1	1

Average Length of Stay		
AIC Avg	Current	Prior
3.93	1.92	3.83

Days/1000		
AIC Avg	Current	Prior
232	63	108

Admits/1000		
AIC Avg	Current	Prior
59	33	28

Inpatient Utilization				
Time Frame	Admits	Paid Per Admit	Paid	PMPM
Current	12	\$12,394	\$148,724	\$34.19
Prior	12	\$17,837	\$214,048	\$41.75

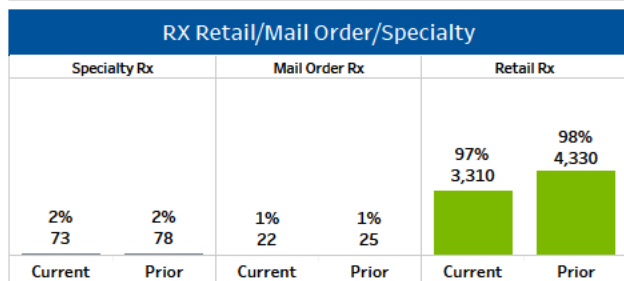
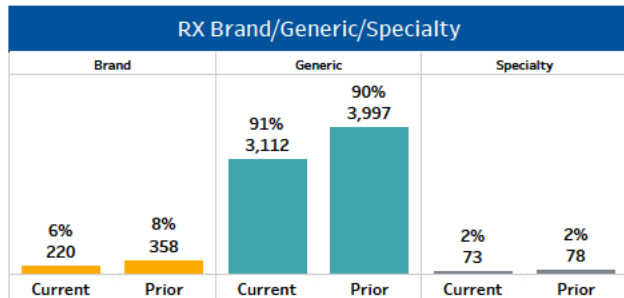
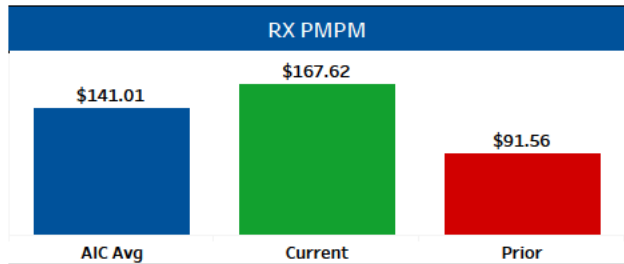
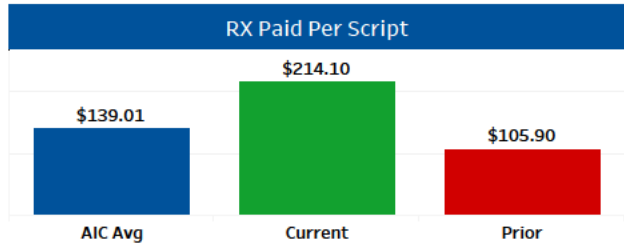
Top Outpatient Hospitals			
Provider Facility	Panel	Paid	DVTs
POMERENE HOSPITAL	Network	\$134,024	1,432
WOOSTER COMMUNITY HOSPITAL	Network	\$86,672	739
WOOSTER AMBULATORY SURGERY CENTER	Network	\$75,046	25
AULTMAN HOSPITAL	Network	\$71,687	292
GENESIS HEALTHCARE SYSTEM	Network	\$62,683	293
	Approved Referrals	\$3,570	26
	Non Network	\$0	2

Outpatient Utilization				
	DVTs	Outpatient Visits	Paid Per Visit	Paid
Current	4,358	869	\$814	\$707,763
Prior	6,168	1,358	\$767	\$1,041,032

IP DRG Detail						
DRG Program	Current			Prior		
	Admits	Days	Paid	Admits	Days	Paid
Cardiac Services	1	3	\$39,220			
General Surgery	2	2	\$33,865			
General Medicine	4	6	\$28,725	3	8	\$12,016
Obstetrics	2	4	\$24,325	3	8	\$56,909
Neonatology	2	7	\$22,589	1	3	\$2,028
Neurology				1	16	\$65,122
Oncology				2	4	\$60,139
Spine				1	2	\$17,835
Other				1	5	\$0
Urology	1	1	\$0			

Outpatient Program Detail						
Dashsubcat	Current			Prior		
	DVTs	Paid	UEs	DVTs	Paid	UEs
OR Services	70	\$155,201	30	117	\$239,251	48
ER LEVEL 3-5	990	\$130,817	50	954	\$106,301	74
Other Outpatient Facility	269	\$101,994	73	558	\$297,023	100
Surgery Center	29	\$80,483	14	14	\$23,452	9
Radiology	185	\$73,287	78	280	\$120,167	109
Supplies	256	\$61,104	31	483	\$56,605	49
Lab/Pathology	1,597	\$58,820	165	2,383	\$89,530	182
Therapies	319	\$27,927	15	424	\$31,957	20
Facility Rx	450	\$13,630	39	712	\$72,342	60
Urgent Care	169	\$2,440	54	179	\$2,018	56
ER LEVEL 1-2	24	\$2,060	9	64	\$2,385	15

RX Total		
Time Frame	Paid	Volume
Current	\$729,013	3,405
Prior	\$469,454	4,433



Top 10 Drugs by Paid								
Drug Name	Class	Brand/Generic	Current			Prior		
			Paid	Vol	UEs	Paid	Vol	UEs
AYVAKIT	ANTINEOPLASTICS	Specialty	\$356,696	9	1	\$38,299	1	1
DUPIXENT	DERMATOLOGICALS	Specialty	\$89,596	23	3	\$48,528	14	2
COSENTYX SENSO	DERMATOLOGICALS	Specialty	\$85,485	12	1	\$93,639	14	1
SKYRIZI PEN	DERMATOLOGICALS	Specialty	\$59,686	3	1	\$55,957	3	1
HUMIRA PEN	ANALGESICS - ANTI-INFLAMMATORY	Specialty	\$30,185	5	1	\$24,705	4	1
JARDIANCE	ANTIDIABETICS	Brand	\$13,011	26	4	\$15,315	33	3
TRULICITY	ANTIDIABETICS	Brand	\$11,761	14	3	\$22,769	30	5
VRAYLAR	ANTIPSYCHOTICS, ANTIMANIC AGENTS	Brand	\$9,428	8	1			
OZEMPIC	ANTIDIABETICS	Brand	\$8,514	11	1	\$7,438	8	2
TIOPRONIN	GENITOURINARY AGENTS - MISCELLANEOUS	Specialty	\$4,916	1	1			
Total			\$669,278	112		\$306,648	107	

Top 10 Drugs by Volume								
Drug Name	Class	Brand/Generic	Current			Prior		
			Paid	Vol	UEs	Paid	Vol	UEs
ATORVASTATIN C	ANTHYPERLIPIDEMICS	Generic	\$812	148	29	\$1,472	221	37
LEVOTHYROXINE	THYROID AGENTS	Generic	\$336	113	24	\$572	148	24
LOSARTAN POTAS	ANTHYPERTENSIVES	Generic	\$482	113	26	\$836	151	25
LISINOPRIL	ANTHYPERTENSIVES	Generic	\$140	108	24	\$340	142	27
AMLODIPINE BES	CALCIUM CHANNEL BLOCKERS	Generic	\$413	102	24	\$555	145	29
HYDROCHLOROTHI	DIURETICS	Generic	\$48	74	18	\$94	106	19
OMEPRAZOLE	ULCER DRUGS	Generic	\$456	70	16	\$515	88	22
METOPROLOL SUC	BETA BLOCKERS	Generic	\$147	63	13	\$548	97	17
VENLAFAXINE HY	ANTIDEPRESSANTS	Generic	\$345	56	13	\$542	76	14
METFORMIN HYDR	ANTIDIABETICS	Generic	\$101	54	16	\$438	82	16
Total			\$3,280	901		\$5,912	1,256	

12 | *Enrollee Questionnaires*

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

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

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

2. **Accident Questionnaire**

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

3. **Designation of Authorized Representative Form**

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

4. **Grievance and Appeal Information**

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

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



13 | *Summary of Benefits and Coverage Guidelines (SBC)*

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

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

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

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



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE:** Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact AultCare at 330-363-6360 or go to www.aultcare.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at www.aultcare.com or call 330-363-6360 or 1-800-344-8858 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	For network providers \$2,500 Individual / \$5,000 Family For out-of-network providers \$7,500 Individual / \$15,000 Family	Generally, you must pay all of the costs from providers up to the calendar year deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Network preventive care and services that apply a copayment are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network medical providers \$2,500 Individual / \$5,000 Family For out-of-network providers \$15,000 Individual / \$30,000 Family For Prescription Drugs \$8,100 Individual / \$16,200 Family	The out-of-pocket limit is the most you could pay in a calendar year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges , penalties, prescription medication coupon, discount or other manufacturer assistance programs for Specialty or other qualified medications, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider ?	Yes. See www.aultcare.com or call 330-363-6360 or 1-800-344-8858 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral .

 All [coinsurance and copayment](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25 copayment /visit	20% coinsurance	Deductible does not apply to office visits with a Network Provider .
	Specialist visit	\$25 copayment /visit	20% coinsurance	
	Preventive care/screening /immunization	No cost share	50% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	20% coinsurance	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.aultcare.com This plan follows the Premium Managed Formulary.	Preferred Generic drugs (Tier 1)	Retail 1-34 day supply: \$10 copayment or 20% coinsurance , whichever is greater; Retail 35-60 day supply: \$20 copayment or 20% coinsurance , whichever is greater; Mail order 90-day supply: \$25 copayment or 20% coinsurance , whichever is greater		Deductible does not apply. Specialty Medications must be obtained from AultCare's Preferred Specialty pharmacies. If a prescription drug is purchased without using your card, this Plan will pay up to the allowed amount . Certain Generic Medications may be subject to an incentive, which may reduce member cost share under the Generic Incentive Program. Certain preventive medications may be covered at 100%, with no cost to you. Certain classes of medications require Preauthorization or Step Therapy.
	Preferred Brand / Non-Preferred Generic drugs (Tier 2)	Retail 1-34 day supply: \$30 copayment or 30% coinsurance , whichever is greater; Mail order 90-day supply: \$85 copayment or 25% coinsurance , whichever is greater, up to a maximum of \$200		
	Non-Preferred Brand / Non-Preferred Generic drugs (Tier 3)	Retail 1-34 day supply: \$45 copayment or 50% coinsurance , whichever is greater; Mail order 90-day supply: \$130 copayment or 45% coinsurance , whichever is greater, up to a maximum of \$400		

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.aultcare.com.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty Generic (Tier 4) **Limited to a 30-day fill	Specialty: \$10 copayment or 20% coinsurance , whichever is greater		Prescription medication coupon, discount, or other manufacturer assistance programs for Specialty or other qualified medications will not apply toward your Deductible or Out-of-Pocket Maximum . For a complete list of these medications and programs, visit the AultCare website at www.aultcare.com .
	Specialty Brand (Tier 5) ***Limited to a 30-day fill	Specialty: \$125 copayment or 20% coinsurance , whichever is greater		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	20% coinsurance	None
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	\$250 copayment /visit	\$250 copayment /visit	Deductible does not apply to this service.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Network deductible will apply.
	Urgent care	\$50 copayment /visit	\$50 copayment /visit	Deductible does not apply to this service.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	0% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Services for Mental Health, Behavioral Health, or Substance Abuse are payable on the same basis as any other illness.
	Inpatient services	0% coinsurance	20% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Cost sharing does not apply to certain preventive services . Depending on the type of service, a copayment , deductible or coinsurance may apply.
	Childbirth/delivery professional services	0% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	20% coinsurance	Preauthorization is required.
If you need help recovering or have other special health needs	Home health care	0% coinsurance	20% coinsurance	Preauthorization is required. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	Benefits paid based on the corresponding medical benefit.	20% coinsurance	Must be injury/illness related. Manipulation therapy is limited to 35 treatments per calendar year.
	Habilitation services	Benefits paid based on the corresponding medical benefit.	Benefits paid based on the corresponding medical benefit.	Services include: Speech/Language/Occupational Therapy, Clinical Therapeutic Intervention including ABA, and Mental/ Behavioral Health Outpatient Services.
	Skilled nursing care	0% coinsurance	20% coinsurance	Preauthorization is required. Coverage is limited to 50 days per calendar year.
	Durable medical equipment	0% coinsurance	20% coinsurance	Preauthorization is required for a single item with a purchase price over \$2,500.
	Hospice services	0% coinsurance	20% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No cost share	50% coinsurance	Coverage is provided for vision screening for all children at least once through age 18 years, to detect the presence of amblyopia or its risk factors.
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
- Abortion (except in cases of rape, incest, or when the life of the mother is endangered, as allowed under applicable law) - Acupuncture	- Bariatric Surgery - Cosmetic Surgery - Dental Care (adult) - Long Term Care	- Non-Emergency care when traveling outside the U.S. - Routine Eye Care (Adult) - Routine Foot Care - Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
- Chiropractic Care - Habilitation Services	Hearing aids are covered in Network at 100%, up to a maximum of \$2,500 per ear once every 4 years through age 21	- Infertility Treatment - Private Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for group health coverage subject to ERISA, contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform; for non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596. Pennsylvania Dutch (Deutsch): Fer Hilf griegie In Deitsch, ruf 330-363-6360 uff.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: for group health coverage subject to ERISA, contact Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform or call the Ohio Department of Insurance 1-800-686-1526; for non-federal governmental group health plans and church plans that are group health plans, contact AultCare at 1-800-344-8858 or call the Ohio Department of Insurance 1-800-686-1526. Pennsylvania Dutch (Deutsch): Fer Hilf griege In Deutsch, ruf 330-363-6360 uff.

Does this plan provide Minimum Essential Coverage? Yes

[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. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

[Pennsylvania Dutch (Deutsch): Fer Hilf griege In Deutsch, ruf 330-363-6360 uff / 1-800-344-8858.]

[Spanish (Español): Para obtener asistencia en Español, llame al 330-363-6360 / 1-800-344-8858.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 330-363-6360 / 1-800-344-8858.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 330-363-6360 / 1-800-344-8858.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 330-363-6360 / 1-800-344-8858.]

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$0
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,560

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,100
Copayments	\$700
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,820

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$25
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,800
Copayments	\$300
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



2600 Sixth Street SW | Canton, Ohio 44710 | 330-363-6360 | 1-800-344-8858 | TTY: 711 | [AultCare.com](https://www.AultCare.com)