



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.aultcare.com](http://www.aultcare.com) or by calling 330-363-6360 or 1-800-344-8858.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>Network:</b> Ind: \$500; E+1: \$1,000; Fam: \$1,000; <b>Non Network:</b> Ind: \$1,000; E+1: \$2,000; Fam: \$2,000; Does not apply to prescription drugs, office visits or preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> . Also, any expenses applied to an individual's <u>deductible</u> , in the last 3 months of a Calendar Year, will apply to that individual's <u>deductible</u> for the following Calendar Year.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	<b>Yes. For network providers:</b> Ind: \$1,500; E+1: \$3,000; Fam: \$3,000; <b>For non-network providers:</b> Ind: \$3,000; E+1: \$6,000; Fam: \$6,000;	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Penalties, premiums, balance-billed charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	<b>Yes.</b> For a list of network providers, see <a href="http://www.aultcare.com">www.aultcare.com</a> or call 330-363-6360 or 1-800-344-8858.	If you use a network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your network doctor or hospital may use a non network <u>provider</u> for some services. Plans use the term network, preferred, or participating for <u>providers</u> in their network. See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	<b>Yes.</b> Please refer to list of exclusions	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about <u>excluded services</u> .

Integrated  
Embedded Deductibles

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- **Co-payments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **co-insurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$25/visit	\$25/visit then 40% coinsurance	--none--
	Specialist visit	\$35/visit	\$35/visit then 40% coinsurance	--none--
	Other practitioner office visit	Chiropractic care: \$35 per office visit and \$5/visit then 20% coinsurance for other services: Podiatry care: \$30 per office visit and \$5/visit then 20% coinsurance for other services	Chiropractic care: \$35 per office visit and \$10/visit then 40% coinsurance for other services: Podiatry care: \$30 per office visit and \$10/visit then 40% coinsurance for other services	Coverage for chiropractic care is limited to 30 visits per calendar year.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
	Preventive care/screening/immunization	No charge	Not covered; Well child care (to age 2): \$20/visit then 40% coinsurance; Well child immunizations (to 19 months): 40% coinsurance;	--none--
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance Union Hospital only; additional \$5/visit when performed at other network providers;	Inpatient: 40% coinsurance; Outpatient/office: \$10/visit then 40% coinsurance;	--none--
	Imaging (CT/PET scans, MRIs)			--none--
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available at <a href="http://www.aultcare.com">www.aultcare.com</a> .	Generic drugs	15%; Min of \$5/Max of \$70		A 34-day supply is available at the Union Hospital Pharmacy. You may obtain a 90 day supply of your maintenance medications. The Union Hospital Pharmacy must fill your prescription for the exact quantity of medications prescribed by your doctor, up to the 90-day plan limit. "30 days plus 2 refills" does not equal one prescription written for "90 days". For prescriptions purchased outside of Union Hospital Pharmacy, members must manually submit prescription receipts for consideration.
	Formulary drugs	30%; Min of \$15/Max of \$100		
	Non Formulary drugs	45%; Min of \$30/Max of \$150;		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	--none--
	Physician/surgeon fees	20% coinsurance	40% coinsurance	--none--

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
<b>If you need immediate medical attention</b>	Emergency room services	\$100/ visit then 0% coinsurance	\$100/visit then 0% coinsurance	Network deductible will apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Network deductible will apply.
	Urgent care	0% coinsurance	0% coinsurance	Network deductible will apply. Urgent Care provided by First Care in Union Hospital is payable after a \$15/visit.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	--none--

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	Office: \$35/ visit; Outpatient: 20% coinsurance Union Hospital only; additional \$5/visit when performed at other network providers;	Office: \$35/visit then 40% coinsurance; Outpatient: \$10/visit then 40% coinsurance;	--none--
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.
	Substance use disorder outpatient services	Office: \$35/ visit; Outpatient: 20% coinsurance Union Hospital only; additional \$5/visit when performed at other network providers;	Office: \$35/visit then 40% coinsurance; Outpatient: \$10/visit then 40% coinsurance;	--none--
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.
<b>If you are pregnant</b>	Prenatal and postnatal care	20% coinsurance	40% coinsurance	--none--
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	A 50% penalty reduction of covered benefits may apply for failure to precertify.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	20% coinsurance	50% coinsurance	Utilization Management approval required. Coverage is limited to 60 visits per calendar year.
	Rehabilitation services	Speech, occupational, and physical therapy- Inpatient: 20% coinsurance; Office: \$15/ visit then 20% coinsurance; Outpatient: 20% coinsurance Union Hospital only; additional \$15/visit when performed at other network providers;	Speech, occupational, and physical therapy- Inpatient:40% coinsurance; Outpatient/ Office: \$20/visit then 40% coinsurance;	Must be illness/injury related.
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	20% coinsurance	40% coinsurance	Utilization Management approval required. Coverage is limited to 50 days per illness.
	Durable medical equipment	20% coinsurance	50% coinsurance	Utilization Management approval required for a single item with a purchase price over \$1,000.
	Hospice service	20% coinsurance	50% coinsurance	Utilization Management approval required.
<b>If your child needs dental or eye care</b>	Eye exam	No charge	40% coinsurance	Coverage is provided for vision screening for all children at least once between the ages of 3 and 5 years, to detect the presence of amblyopia or its risk factors.

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		Network Provider	Non-network Provider	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

**Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> <li>• Cosmetic Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Dental Care (adult)</li> <li>• Hearing Aids</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Eye Care (adult)</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Acupuncture (Union Hospital only)</li> <li>• Bariatric Surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Chiropractic Care</li> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency Care when traveling outside the U.S.</li> <li>• Private Duty Nursing</li> </ul>

**Your Rights to Continue Coverage:**

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, **contact the plan at 330-363-6360 or 1-800-344-8858**. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: AultCare Customer Service Center at 330-363-6360 or 1-800-344-8858, or send your appeal or grievance in writing to our Grievance and Appeal Coordinator at P.O. Box 6029, Canton, Ohio 44706-0910, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

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, kwiiijigo 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 page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,010
- Patient pays \$1,530

**Sample care costs:**

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$500
Co-pays	\$0
Co-insurance	\$1,000
Limits or exclusions	\$30
<b>Total</b>	<b>\$1,530</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,000
- Patient pays \$1,400

**Sample care costs:**

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$300
Co-pays	\$160
Co-insurance	\$660
Limits or exclusions	\$80
<b>Total</b>	<b>\$1,400</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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## AultCare/Aultra Notice Tag Lines for the State of Ohio

### English

**This Notice has Important Information.** This notice has important information about your application or coverage through **AultCare/Aultra**. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. **Call Local: 330.363.6360 Outside Stark County: 1.800.344.8858 TTY Local: 330.363.2393 Outside Stark County: 1.866.633.4752**

### Spanish

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través **AultCare/Aultra**. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al **Local : 330.363.6360 Fuera del condado de Stark : 1.800.344.8858 TTY Local : 330.363.2393 Fuera del condado de Stark : 1.866.633.4752**

### Chinese

本通知有重要的訊息。本通知有關於您透過 **AultCare/Aultra** 保險公司 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 本地： **330.363.6360 斯塔克縣外： 1.800.344.8858 TTY 線 本地： 330.363.2393 斯塔克縣外： 1.866.633.4752**。

### German

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch **AultCare/Aultra**. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY –Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

### Arabic

يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار على معلومات مهمة بخصوص طلبك للحصول على التغطية من خلال شركة التأمين **AultCare/Aultra**. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ اجراء في تواريخ معينة للحفاظ على تغطيتك الصحية او للمساعدة في دفع التكاليف. لك الحق في الحصول على المعلومات والمساعدة بلغتك من دون أي تكلفة. اتصل بـ **330.363.6360** خارج مقاطعة ستارك : **1.866.633.4752** خارج مقاطعة ستارك : **1.800.344.8858 TTY**

### Pennsylvania Dutch

Die Bekanntmachung gebt wíchdichi Auskunft. Die Bekanntmachung gebt wíchdichi Auskunft baut dei Application oder Coverage mit **AultCare/Aultra**. Geb Acht fer wíchdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmdie Deadlines, so ass du dei Health Coverage bhalde kannscht, odder bezaahle helfe kannscht. Du hoscht es Recht fer die Information un Hilf in deinre eegne Schprooch griege, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY – Linie Local: 330.363.2393 Außerhalb von Stark County : 1.866.633.4752.**

### Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через **Страховая компания AultCare/Aultra**. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуются принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону **Местный: 330.363.6360 Вне Старка County : 1.800.344.8858 TTY линия Местный: 330.363.2393 Вне Старка County : 1.866.633.4752.**

### French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de **Compagnie d'Assurance AultCare/Aultra**. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez **En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 330.363.2393 En dehors du comté de Stark : 1.866.633.4752**

### Vietnamese

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình **Công ty Bảo hiểm AultCare/Aultra**. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số **Địa phương: 330.363.6360 Bên ngoài của Stark County : 1.800.344.8858 TTY đường dây Địa phương: 330.363.2393 Bên ngoài của Stark County : 1.866.633.4752.**

### Cushite-Oromo

Beeksisi kun odeeffannoo barbaachisaa qaba. Beeksisi kun sagantaa yookan karaa **AultCare/Aultra** tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala

ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 330.363.2393 Outside of Stark County: 1.866.633.4752** tii bilbilaa.

## Korean

한국어  
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 **AultCare/Aultra 보험 회사계획** 을 통한 커버리지 에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 지역 : **330.363.6360 스타크 카운티 의 외부 : 1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티 의 외부 : 1.866.633.4752** 로 전화하십시오.

## Italian

Italiano  
Questo avviso contiene informazioni importanti sulla tua domanda o copertura attraverso **AultCare/Aultra**. Cerca le date chiave in questo avviso. Potrebbe essere necessario un tuo intervento entro una scadenza determinata per consentirti di mantenere la tua copertura o sovvenzione. Hai il diritto di ottenere queste informazioni e assistenza nella tua lingua gratuitamente. Chiama **Locale: 330.363.6360 Al di fuori di Stark County : 1.800.344.8858 TTY linea Locale: 330.363.2393 Al di fuori di Stark County : 1.866.633.4752**.

## Japanese

日本語  
この通知には重要な情報が含まれています。この通知には **AultCare/Aultra 保険会社** の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。**330.363.6360 スターク郡の外 : 1.800.344.8858 TTY ライン ローカル : 330.363.2393 スターク郡の外 : 1.866.633.4752** までお電話ください。

## Dutch

Nederlands  
Deze mededeling heeft belangrijke informatie. Deze mededeling heeft belangrijke informatie over uw aanvraag of dekking via **AultCare/Aultra**. Kijk naar belangrijke datums in deze mededeling. Het kan nodig zijn om actie te ondernemen binnen bepaalde termijnen om uw zorgverzekering te behouden of hulp met kosten te krijgen. U heeft het recht op deze informatie en hulp in uw taal zonder kosten. Bel **Local : 330.363.6360 Buiten Stark County : 1.800.344.8858 TTY Line Local : 330.363.2393 Buiten Stark County : 1.866.633.4752**.

## Ukrainian

український  
Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страховального покриття через **Страхова компанія AultCare/Aultra**. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону **Місцевий : 330.363.6360 Поза Старка County : 1.800.344.8858 TTY лінія Місцевий : 330.363.2393 Поза Старка County : 1.866.633.4752**.

## Romanian

Română  
Prezenta notificare conține informații importante. Această notificare conține informații importante privind cererea sau acoperirea asigurării dumneavoastră de sănătate prin **Compania de Asigurari AultCare/Aultra**. Căutați datele cheie din această notificare. Este posibil să fie nevoie să acționați până la anumite termene limită pentru a vă menține acoperirea asigurării de sănătate sau asistența privitoare la costuri. Aveți dreptul de a obține gratuit aceste informații și ajutor în limba dumneavoastră. Sunați la **Locale : 330.363.6360 In afara Stark Judet : 1.800.344.8858 TTY linie Locale : 330.363.2393 In afara Stark Judet : 1.866.633.4752**.

### Non-Discrimination Notice:

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If you need these services, or if you believe that AultCare/Aultra has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can contact or file a grievance with the: AultCare/Aultra Civil Rights Coordinator, 2600 6<sup>th</sup> St. S.W. Canton, OH 44710, 330-363-7456, [CivilRightsCoordinator@aultcare.com](mailto:CivilRightsCoordinator@aultcare.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights staff is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.