


**AULTCARE: Silver 6850 No Pediatric Dental**

Coverage for: Individual/Family | Plan Type: PPO



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, call AultCare at 330-363-6360. 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.aultcas.com/aultcare/login.aspx](http://www.aultcas.com/aultcare/login.aspx) or call 330-363-6360 or 1-800-344-8858 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <u>deductible</u> ?                             | For <u>network providers</u><br>\$6,850 Individual / \$13,700 Family;<br>For <u>out-of-network providers</u><br>\$20,550 Individual / \$41,100 Family | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <u>deductibles</u> for specific services?           | No.   | You don't have to meet <u>deductibles</u> for specific services.  |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | For <u>network providers</u><br>\$6,850 Individual / \$13,700 Family<br>For <u>out-of-network providers</u><br>\$22,050 Individual / \$44,100 Family  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , penalties, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.  | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .  |
| Will you pay less if you use a <u>network provider</u> ?            | Yes. See <a href="http://www.aultcare.com">www.aultcare.com</a> or call 330-363-6360 or 1-800-344-8858 for a list of <u>network providers</u> .       | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No  | You can see the <u>specialist</u> you choose without a <u>referral</u> .  |

 All [copayment](#) and [coinsurance](#) 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<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | First 4 office visits (primary care physician and specialist combined): \$10 <a href="#">copayment</a> /visit.<br><br>All other office visits: 0% <a href="#">coinsurance</a>                           | 20% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to the first 4 <a href="#">Network</a> office visits of the benefit period (primary care physician and specialist combined).  |
|  | <a href="#">Specialist</a> visit                       | First 4 office visits (primary care physician and specialist combined): \$25 <a href="#">copayment</a> /visit.<br><br>All other office visits: 0% <a href="#">coinsurance</a>                           | 20% <a href="#">coinsurance</a>                    | <a href="#">Deductible</a> does not apply to the first 4 <a href="#">Network</a> office visits of the benefit period (primary care physician and specialist combined).  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 20% <a href="#">coinsurance</a>                    | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    |   |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.aultcare.com">www.aultcare.com</a> | Generic drugs (Tier 1)                                 | Retail: \$10 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater; Mail order: \$30 <a href="#">copayment</a> or 20% <a href="#">coinsurance</a> , whichever is greater. |  | <a href="#">Network deductible</a> will apply to Tier 3 and Tier 4 drugs. A 34-day supply is available at the retail pharmacy for brand name <a href="#">prescription drugs</a> . You may obtain up to a 60-day supply of generic <a href="#">prescription drugs</a> at the retail pharmacy. A 90-day supply is available at the mail order program. If a <a href="#">prescription drug</a> is purchased without using your card, this <a href="#">Plan</a> will pay up to the <a href="#">allowed amount</a> . |
|  | Preferred brand (Tier 2)                               | Retail: \$20 <a href="#">copayment</a> or 30% <a href="#">coinsurance</a> , whichever is greater; Mail order: \$55 <a href="#">copayment</a> or 25% <a href="#">coinsurance</a> , whichever is greater  |  |   |
|  | Non-Preferred brand (Tier 3)                           | 0% <a href="#">coinsurance</a> (after deductible)   |  |   |
|  | Specialty drugs (Tier 4)                               | 0% <a href="#">coinsurance</a> (after deductible)   |  |   |
| If you have outpatient surgery   | Facility fee (e.g., ambulatory surgery center)         | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | None  |
|  | Physician/surgeon fees                                 | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | None  |

| Common Medical Event  | Services You May Need                            | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information  |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 0% <a href="#">coinsurance</a>  | 0% <a href="#">coinsurance</a>                     | <a href="#">Network deductible</a> will apply.  |
|   | <a href="#">Emergency medical transportation</a> | 0% <a href="#">coinsurance</a>  | 0% <a href="#">coinsurance</a>                     | <a href="#">Network deductible</a> will apply.  |
|   | <a href="#">Urgent care</a>                      | \$75 <a href="#">copayment</a> /visit   | \$75 <a href="#">copayment</a> /visit              | <a href="#">Deductible</a> does not apply to this benefit.  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
|   | Physician/surgeon fees                           | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | First 4 office visits (primary care physician and specialist combined):<br>\$10 <a href="#">copayment</a> /visit.<br><br>All other office visits:<br>0% <a href="#">coinsurance</a> | 20% <a href="#">coinsurance</a>                    | None  |
|   | Inpatient services                               | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
| If you are pregnant   | Office Visits                                    | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.   |
|   | Childbirth/delivery professional services        | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | None  |
|   | Childbirth/delivery facility services            | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. Coverage is limited to 100 visits per calendar year.  |
|   | <a href="#">Rehabilitation services</a>          | 0% <a href="#">coinsurance</a>  | 20% <a href="#">coinsurance</a>                    | Must be illness/injury related. Coverage for outpatient cardiac rehabilitation is limited to 36 visits per calendar year. Outpatient speech therapy is limited to 20 visits per calendar year; outpatient occupational and physical therapy is limited to 40 visits combined per calendar year. |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                            |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |   |
|  | <a href="#">Habilitation services</a>     | 0% <a href="#">coinsurance</a>               | 20% <a href="#">coinsurance</a>                    | Coverage includes, but is not limited to Autism Spectrum Disorder. Services are limited to the following: Speech/Language/Occupational Therapy - 20 visits per calendar year for each service; and Clinical Therapeutic Intervention including ABA at 20 hours per week; and Mental/ Behavioral Health Outpatient Services. |
|  | <a href="#">Skilled nursing care</a>      | 0% <a href="#">coinsurance</a>               | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required. Coverage is limited to 90 days per calendar year.   |
|  | <a href="#">Durable medical equipment</a> | 0% <a href="#">coinsurance</a>               | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required for a single item with a purchase price over \$1,000.  |
|  | <a href="#">Hospice services</a>          | 0% <a href="#">coinsurance</a>               | 20% <a href="#">coinsurance</a>                    | <a href="#">Preauthorization</a> is required.   |
| If your child needs dental or eye care | Children's eye exam                       | No charge                                    | 20% <a href="#">coinsurance</a>                    | Coverage limited to one visit/year to age 19.   |
|  | Children's glasses                        | 0% <a href="#">coinsurance</a>               | 20% <a href="#">coinsurance</a>                    | Coverage limited to standard frames and lenses up to one pair per calendar year. In lieu of glasses, contacts are covered and limited to 1 prescription/calendar year to age 19.  |
|  | 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)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (adult)
- Hearing Aids
- Infertility Treatment
- 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
- 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](http://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.ccio.cms.gov](http://www.ccio.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](http://www.HealthCare.gov) or call 1-800-318-2596.

**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](http://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.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet 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:

[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 300-363-6360 / 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.*-----

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](#) \$6,850
- [Specialist coinsurance](#) 0%
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$6,850        |
| Copayments                        | \$0            |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$260          |
| <b>The total Peg would pay is</b> | <b>\$5,250</b> |

**Managing Joe's type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$6,850
- [Specialist coinsurance](#) 0%
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,220        |
| Copayments                        | \$400          |
| Coinsurance                       | \$1,070        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$4,000</b> |

**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$6,850
- [Specialist coinsurance](#) 0%
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |              |
|-----------------------------------|--------------|
| Deductibles                       | \$1,742      |
| Copayments                        | \$50         |
| Coinsurance                       | \$           |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>1,792</b> |

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

## 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

Español

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

### Chinese

中文

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

Deutsche

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

### Arabic

العربية

يوضح هذا إشعار لأولئك الذين لديهم طلب للحصول على تأمين طبي أو تأمين صحي من خلال شركة التأمين AultCare/Aultra. يبحث عن التأمين الصحي لهذا الإشعار. يرجى إجراء ما يلي: تأكد من أن جميع المعلومات المطلوبة في الإشعار صحيحة. اتصل بالرقم 330.363.6360 أو 1.800.344.8858 للحصول على مزيد من المعلومات. يرجى الاتصال بالرقم 330.363.2393 أو 1.866.633.4752 للحصول على مزيد من المعلومات.

### Pennsylvania Dutch

Deitsch

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 beschtimme 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

русский

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

### French

Français

Cet avis d'importantes informations. Cet avis d'importantes informations sur votre demande ou la couverture par l'intermédiaire de **Compagnie d'Assurance AultCare/Aultra**. Recherchez les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. **Appelez Locale: 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local: 330.363.2393 En dehors du comté de Stark : 1.866.633.4752**

### Vietnamese

Việt Nam

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bản 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 trọng 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

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa **AultCare/Aultra** tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa **Local: 330.363.6360 Outside of Stark County: 1.800.344.8858 TTY Line Local: 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 회사계획을 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하의 건강의 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 카운티의 외부 : **1.800.344.8858 TTY 라인 지역 : 330.363.2393 스타크 카운티의 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**.

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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>.