



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 \$1,800 Individual / \$3,600 Family For out-of-network providers \$5,400 Individual / \$10,800 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 benefits 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 providers \$1,800 Individual / \$3,600 Family For out-of-network providers \$28,350 Individual/ \$56,700 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, prescription drug coupon, discount or assistance programs, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| 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](#) 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 | First 4 office visits (PCP and specialist combined): \$10 copayment /visit All other office visits: 0% coinsurance | 20% coinsurance | Deductible does not apply to the first 4 Network office visits of the benefit period (primary care physician and specialist combined). |
| | Specialist visit | First 4 office visits (PCP and specialist combined): \$25 copayment All other office visits: 0% coinsurance | 20% coinsurance | |
| | Preventive care/screening/immunization | No charge | 20% 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 | Generic drugs (Tier 2 - Preferred Generic drugs) | Retail: \$10 copayment or 20% coinsurance , whichever is greater; Mail order: \$30 copayment or 20% coinsurance , whichever is greater. | Retail: \$10 copayment or 20% coinsurance , whichever is greater; Mail order: \$30 copayment or 20% coinsurance , whichever is greater. | Network Deductible will apply to Tiers 4, 5, and 6. Tier 1 Preventive drugs may be covered at 100%, with no cost to you. A 34-day supply is available at the retail pharmacy for generic and brand name prescription drugs . You may obtain up to a 60-day supply of Tier 1 and Tier 2 prescription drugs at the retail pharmacy for |

[* 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 |
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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| coverage is available at www.aultcare.com This plan follows the Marketplace Managed Formulary. | Preferred Brand drugs (Tier 3 - Non-Preferred Generic / Preferred Brand drugs) | Retail: \$20 copayment or 30% coinsurance , whichever is greater; Mail order: \$55 copayment or 25% coinsurance , whichever is greater | Retail: \$20 copayment or 30% coinsurance , whichever is greater; Mail order: \$55 copayment or 25% coinsurance , whichever is greater | the mail order amount. A 90-day supply of Preventive/Generic/Brand drugs are available through the mail order program. Specialty drugs are limited to a 30-day fill and must be obtained from AultCare's Preferred Specialty Pharmacies. If a prescription is purchased without using your card, the plan will pay up to the allowed amount . |
| | Non-Preferred Brand drugs (Tier 4 - Non-Preferred Generic / Non-Preferred Brand drugs) | Retail or Mail order: 0% coinsurance after Network Deductible | Retail or Mail order: 0% coinsurance after Network Deductible | Certain Generic Medications may be subject to an incentive which may reduce member cost share under the Generic Incentive Program. |
| | Specialty drugs (Tier 5 and 6 – Preferred Generic Specialty and Preferred Brand Specialty) | Retail or Mail order: 0% coinsurance after Network Deductible | Retail or Mail order: 0% coinsurance after Network Deductible | Certain prescription drug coupon, discount, or assistance programs will not apply toward your Deductible or Out-of-Pocket Maximum. Certain classes of medications require a Prior Authorization or Step Therapy. For a complete list of these medications, please visit the AultCare website at www.aultcare.com . |
| 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 | 0% coinsurance | 0% coinsurance | Network deductible will apply. |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | Network deductible will apply. |
| | Urgent care | \$75 copayment | \$75 copayment | 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 recommended. |

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| 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) | |
| | Physician/surgeon fees | 0% coinsurance | 20% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 0% coinsurance | 20% coinsurance | 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 recommended. |
| If you are pregnant | Office visits | 0% coinsurance | 20% coinsurance | 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 recommended. |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 20% coinsurance | Preauthorization is recommended. Coverage is limited to 100 visits per calendar year. |
| | Rehabilitation services | 0% coinsurance | 20% coinsurance | 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. Manipulation therapy is limited to 12 treatments per calendar year. |
| | Habilitation services | 0% coinsurance | 20% coinsurance | 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 |

| 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) | |
| | | | | including ABA at 20 hours per week; and Mental/ Behavioral Health Outpatient Services. |
| | Skilled nursing care | 0% coinsurance | 20% coinsurance | Preauthorization is recommended. Coverage is limited to 90 days per calendar year. |
| | Durable medical equipment | 0% coinsurance | 20% coinsurance | Preauthorization is recommended for a single item with a purchase price over \$2,500. |
| | Hospice services | 0% coinsurance | 20% coinsurance | Preauthorization is recommended. |
| If your child needs dental or eye care | Children's eye exam | No charge | 20% coinsurance | Coverage limited to one visit/year to age 19. |
| | Children's glasses | 0% coinsurance | 20% coinsurance | 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 .) | | | |
|---|--|---|--|
| <ul style="list-style-type: none"> Abortion (except in cases of rape, incest, or when the life of the mother is endangered, as allowed under applicable law) Acupuncture Bariatric Surgery | <ul style="list-style-type: none"> Cosmetic Surgery Dental Care Hearing Aids Infertility Treatment Long Term Care | <ul style="list-style-type: none"> 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.) | | |
|--|---|--|
| <ul style="list-style-type: none"> Chiropractic Care | <ul style="list-style-type: none"> Habilitation Services | <ul style="list-style-type: none"> 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

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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.

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.

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? Not Applicable

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 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): Dinekehgo 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.

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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 | \$1,800 |
| ■ 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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,860 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,800 |
| ■ 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:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$200 |
| Coinsurance | \$800 |
| What isn't covered | |
| 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 | \$1,800 |
| ■ 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 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,800 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,800 |

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: 711 Outside Stark County: 711**

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 : 711 Fuera del condado de Stark : 711**

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：711 斯塔克縣外： 711**。

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: 711 Außerhalb von Stark County : 711**

Arabic

العربية

يحتوي هذا الإشعار معلومات هامة. يحتوي هذا الإشعار معلومات مهمة بخصوص طلبك للحصول على التغطية من خلا 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: 1.800.344.8858 لخط TTY المحلي: 711 خارج مقاطعة ستارك: 711

Pennsylvania Dutch

Deitsch

Die Bekanntmachung gebt wichdichi Auskunft. Die Bekanntmachung gebt wichdichi Auskunft baut dei Application oder Coverage mit **AultCare/Aultra**. Geb Acht fer wichdiche Daadem in die Bekanntmachung. Es iss meeglich, ass du ebbes duh muscht, an beschtimmdede 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 grieghe, un die Hilf koschtet nix **Local: 330.363.6360 Außerhalb von Stark County : 1.800.344.8858 TTY – Linie Local: 711 Außerhalb von Stark County : 711.**

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: 711 Вне Старка County : 711.**

French

Français

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 Locale: 330.363.6360 En dehors du comté de Stark : 1.800.344.8858 ligne ATS Local : 711 En dehors du comté de Stark : 711**

Vietnamese

Việt Nam

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: 711 Bên ngoài của Stark County : 711.**

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 dhuma 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: 711 Outside of Stark County: 711** 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. 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 카운티의 외부 : **1.800.344.8858 TTY 라인 지역 : 711** 스타크 카운티의 외부 : **711** 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: 711 Al di fuori di Stark County : 711**.

Japanese

日本語
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Dutch

Nederlands
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Ukrainian

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Romanian

Română
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