

# Appendix I

Summary of Benefits and Coverage: What this [Plan](#) Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024 - 12/31/2024

Coverage for: Individual + Family | Plan Type: PPO


City Of Canton: Anthem Blue Access PPO \$350



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, <https://eoc.anthem.com/eocdps/aso>. 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.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call (844) 995-1752 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$350/person or \$700/family for In- <a href="#">Network Providers</a> . \$350/person or \$700/family for Non- <a href="#">Network Providers</a> .	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive Care</a> . For more information see below.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,350/person or \$2,700/family for In- <a href="#">Network Providers</a> . \$2,350/person or \$4,700/family for Non- <a href="#">Network Providers</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, health care this <a href="#">plan</a> doesn't cover, and Non- <a href="#">Network Transplants</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.anthem.com/find-care/?alphaprefix=AKH">www.anthem.com/find-care/?alphaprefix=AKH</a> or call (844) 995-1752 for a list of <a href="#">network providers</a> . Costs may vary by site of service and how	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

	the <a href="#">provider</a> bills.	
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Virtual visits (Telehealth) benefits available.
	<a href="#">Preventive care</a> / <a href="#">screening</a> / immunization	No charge	30% <a href="#">coinsurance</a>	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.[insert]</a> .	Typically Generic (Tier 1)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	Carved out to OptumRx
	Typically Preferred Brand & Non-Preferred Generic Drugs (Tier 2)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
	Typically Non-Preferred Brand and Generic drugs (Tier 3)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
	Typically Preferred <a href="#">Specialty</a> (brand and generic) (Tier 4)	Not covered (retail and home delivery)	Not covered (retail and home delivery)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$200/visit <a href="#">deductible</a> does not apply	Covered as In- <a href="#">Network</a>	<a href="#">Copayment</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	Covered as In- <a href="#">Network</a>	-----none-----
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Physician/surgeon fees	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit 20% <a href="#">coinsurance</a> Other Outpatient 20% <a href="#">coinsurance</a>	Office Visit 30% <a href="#">coinsurance</a> Other Outpatient 30% <a href="#">coinsurance</a>	Office Visit Virtual visits (Telehealth) benefits available. Other Outpatient -----none-----
	Inpatient services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	-----none-----
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	100 visits/benefit period for Home Health and Private Duty Nursing combined.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	*See Therapy Services section.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	120 days/benefit period for skilled nursing services.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	*See <a href="#">Durable Medical Equipment</a> Section
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	-----none-----
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	-----none-----
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Children's dental check-up</li> <li>Eye exams for a child</li> <li>Long-term care</li> <li>Weight loss programs</li> </ul>	<ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Glasses for a child</li> <li>Routine eye care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Infertility treatment</li> <li>Routine foot care</li> </ul>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://eoc.anthem.com/eocdps/aso>.

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Acupuncture
- Hearing aids 1 item/hearing-impaired ear every 4 years with a \$3,000 maximum/hearing-impaired ear
- Bariatric surgery
- Most coverage provided outside the United States. See [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Chiropractic care 30 visits/benefit period
- Private-duty nursing 100 visits/benefit period combined with Home Health

**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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300, Columbus, Ohio 43215, (800) 686-1526, (614) 644-2673, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov). 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 on how 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, [www.cciio.cms.gov](http://www.cciio.cms.gov)

**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/No.**

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](#).

*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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350	■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$350
■ <a href="#">Specialist coinsurance</a>	20%	■ <a href="#">Specialist coinsurance</a>	20%	■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%	■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%	■ Other <a href="#">coinsurance</a>	20%
<p>This EXAMPLE event includes services like:</p> <p><a href="#">Specialist</a> office visits (<i>prenatal care</i>)            Childbirth/Delivery Professional Services            Childbirth/Delivery Facility Services  <a href="#">Diagnostic tests</a> (<i>ultrasounds and blood work</i>)  <a href="#">Specialist</a> visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Primary care physician</a> office visits (<i>including disease education</i>)  <a href="#">Diagnostic tests</a> (<i>blood work</i>)  <a href="#">Prescription drugs</a>  <a href="#">Durable medical equipment</a> (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like:</p> <p><a href="#">Emergency room care</a> (<i>including medical supplies</i>)  <a href="#">Diagnostic test</a> (<i>x-ray</i>)  <a href="#">Durable medical equipment</a> (<i>crutches</i>)  <a href="#">Rehabilitation services</a> (<i>physical therapy</i>)</p>	
<b>Total Example Cost</b>	<b>\$12,700</b>	<b>Total Example Cost</b>	<b>\$5,600</b>	<b>Total Example Cost</b>	<b>\$2,800</b>
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>		<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$350	<a href="#">Deductibles</a>	\$350	<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$0	<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$1,000	<a href="#">Coinsurance</a>	\$200	<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$70	Limits or exclusions	\$4,300	Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$1,420</b>	<b>The total Joe would pay is</b>	<b>\$4,850</b>	<b>The total Mia would pay is</b>	<b>\$960</b>

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

## Language Access Services:

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (844) 995-1752

**Amharic (አማርኛ):** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገና የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (844) 995-1752 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (844) 995-1752.

**Armenian (հայերեն):** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (844) 995-1752:

**Bassa (Bàsɔ̀ Wùdù):** M̄ dyi dyi-diè-djè b̄é b̄édjé b̄á céè-djè nià ke dyí ní, ɔ̀ m̀ò nì dyí-b̄édjèin-djè b̄é m̀ ké gbo-kpá-kpá kè b̄ǎ kpǎ djé m̀ bídjí-wùdùùn b̄ó pídyi. B̄é m̀ ké wuɖu-zìin-nyò d̀ò gbo wùdù ke, d̄á (844) 995-1752.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (844) 995-1752 -তে কল করুন।

**Burmese (မြန်မာ):** ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (844) 995-1752 သို့ ခေါ်ဆိုပါ။

**Chinese (中文):** 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(844) 995-1752。

**Dinka (Dinka):** Na nɔŋ thiëc në ke de yä thorë, ke yin nɔŋ loŋ bē yi kuony ku wër alëu bē gɛɛr yic yin ne thoŋ du ke cin wëu tääuë ke piny. Te kør yin ba jam wënë ran ye thok geryic, ke yin cəl (844) 995-1752.

**Dutch (Nederlands):** Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (844) 995-1752.

**Farsi (فارسي):** در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (844) 995-1752 تماس بگیرید.

## Language Access Services:

**French (Français) :** Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (844) 995-1752.

**German (Deutsch):** Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (844) 995-1752.

**Greek (Ελληνικά)** Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (844) 995-1752.

**Gujarati (ગુજરાતી):** જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (844) 995-1752.

**Haitian Creole (Kreyòl Ayisyen):** Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (844) 995-1752.

**Hindi (हिंदी):** अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (844) 995-1752 ।

**Hmong (White Hmong):** Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (844) 995-1752.

**Igbo (Igbo):** O bur u na i nwere ajuju o buła gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o buła. Ka gi na okowa okwu kwuo okwu, kpoo (844) 995-1752.

**Ilokano (Ilokano):** Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (844) 995-1752.

**Indonesian (Bahasa Indonesia):** Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (844) 995-1752.

**Italian (Italiano):** In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (844) 995-1752

**Japanese (日本語):** この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには (844) 995-1752 にお電話ください。

## Language Access Services:

**Khmer (ខ្មែរ):** បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។  
ដើម្បីជ្រកជាមួយអ្នកបកប្រែ សូមហៅ(844) 995-1752 ។

**Kirundi (Kirundi):** Ugize ikibazo ico arico cose kuri iyi nyandiko, ufise uburenganzira bwo kuronka ubufasha mu rurimi rwawe ata giciro. Kugira uvugishe umusemuzi, akura (844) 995-1752.

**Korean (한국어):** 본 문서에 대해 어떠한 문의사항이라도 있을 경우, 귀하에게는 귀하가 사용하는 언어로 무료 도움 및 정보를 얻을 권리가 있습니다. 통역사와 이야기하려면(844) 995-1752 로 문의하십시오.

**Lao (ພາສາລາວ):** ຖ້າທ່ານມີຄໍາຖາມໃດໆກ່ຽວກັບເອກະສານນີ້, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໃດໆບໍ່ເສຍຄ່າ.  
ເພື່ອໂອ້ນລັບກັບວ່າມແປພາສາ, ໃຫ້ໃບທາ (844) 995-1752.

**Navajo (Diné):** Dii naaltsoos biká'ígíí lahgo bina'idíilkidgo ná bohónéedzǎ dóó bee ahóót'i' t'áá ni nizaad k'ehǫ́ bee nił hodoonih t'áadoo bááh ilínígóó. Ata' halne'ígíí la' bich'í' hadeesdzih nínizingo kojí' hodiilnih (844) 995-1752.

**Nepali (नेपाली):** यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।  
दोभाषेसँग कुरा गर्नका लागि, यहाँ कल गर्नुहोस् (844) 995-1752

**Oromo (Oromifaa):** Sanadi kanaa wajjin walqabaate gaffi kamiyuu yoo qabduu tanaan, Gargaarsa argachuu fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana dubaachuuf, (844) 995-1752 bilbilla.

**Pennsylvania Dutch (Deutsch):** Wann du Frooge iwwer selle Document hoscht, du hoscht die Recht um Hilfe un Information zu griege in dei Schprooch mitaus Koscht. Um mit en Iwwersetze zu schwetze, ruff (844) 995-1752 aa.

**Polish (polski):** W przypadku jakichkolwiek pytań związanych z niniejszym dokumentem masz prawo do bezpłatnego uzyskania pomocy oraz informacji w swoim języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer (844) 995-1752.

**Portuguese (Português):** Se tiver quaisquer dúvidas acerca deste documento, tem o direito de solicitar ajuda e informações no seu idioma, sem qualquer custo. Para falar com um intérprete, ligue para (844) 995-1752.

**Punjabi (ਪੰਜਾਬੀ):** ਜੇ ਤੁਹਾਡੇ ਇਸ ਦਸਤਾਵੇਜ਼ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹੁੰਦੇ ਹਨ ਤਾਂ ਤੁਹਾਡੇ ਕੋਲ ਮੁਫਤ ਵਿੱਚ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੁੰਦਾ ਹੈ। ਇੱਕ ਦੁਬਾਸੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ(844) 995-1752 ਤੇ ਕਾਲ ਕਰੋ।



## Language Access Services:

**Romanian (Română):** Dacă aveți întrebări referitoare la acest document, aveți dreptul să primiți ajutor și informații în limba dumneavoastră în mod gratuit. Pentru a vă adresa unui interpret, contactați telefonic (844) 995-1752.

**Russian (Русский):** Если у вас есть какие-либо вопросы в отношении данного документа, вы имеете право на бесплатное получение помощи и информации на вашем языке. Чтобы связаться с устным переводчиком, позвоните по тел. (844) 995-1752.

**Samoan (Samoa):** Afai e iai ni ou fesili e uiga i lenei tusi, e iai lou 'aia e maua se fesoasoani ma faamatalaga i lou lava gagana e aunoa ma se totogi. Ina ia talanoa i se tagata faaliliu, vili (844) 995-1752.

**Serbian (Srpski):** Ukoliko imate bilo kakvih pitanja u vezi sa ovim dokumentom, imate pravo da dobijete pomoć i informacije na vašem jeziku bez ikakvih troškova. Za razgovor sa prevodiocem, pozovite (844) 995-1752.

**Spanish (Español):** Si tiene preguntas acerca de este documento, tiene derecho a recibir ayuda e información en su idioma, sin costos. Para hablar con un intérprete, llame al (844) 995-1752.

**Tagalog (Tagalog):** Kung mayroon kang anumang katanungan tungkol sa dokumentong ito, may karapatan kang humingi ng tulong at impormasyon sa iyong wika nang walang bayad. Makipag-usap sa isang tagapagpaliwanag, tawagan ang (844) 995-1752.

**Thai (ไทย):** หากท่านมีคำถามใดๆ เกี่ยวกับเอกสารฉบับนี้ ท่านมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของท่านโดยไม่มีค่าใช้จ่าย โดยโทร (844) 995-1752 เพื่อพูดคุยกับล่าม

**Ukrainian (Українська):** якщо у вас виникають запитання з приводу цього документа, ви маєте право безкоштовно отримати допомогу й інформацію вашою рідною мовою. Щоб отримати послуги перекладача, зателефонуйте за номером (844) 995-1752.

**Urdu (اردو):** اگر اس دستاویز کے بارے میں آپ کا کوئی سوال ہے، تو آپ کو مدد اور اپنی زبان میں مفت معلومات حاصل کرنے کا حق حاصل ہے۔ کسی مترجم سے بات کرنے کے لئے، (844) 995-1752 پر کال کریں۔

**Vietnamese (Tiếng Việt):** Nếu quý vị có bất kỳ thắc mắc nào về tài liệu này, quý vị có quyền nhận sự trợ giúp và thông tin bằng ngôn ngữ của quý vị hoàn toàn miễn phí. Để trao đổi với một thông dịch viên, hãy gọi (844) 995-1752.

**(Yiddish) (אידיש):** אויב איר האט שאלות וועגן דעם דאקומענט, האט איר די רעכט צו באקומען דעם אינפארמאציע אין אייער שפראך אהן קיין פרייז. צו רעדן צו אן איבערזעצער, רופט (844) 995-1752.

**Yoruba (Yorùbá):** Tí o bá ní èyíkéyí ìbèrè nípa àkọsílẹ̀ yí, o ní ètọ́ láti gba ìrànwọ́ àti ìwífún ní èdè rẹ̀ lọfẹ́fẹ́. Bá wa ògbùfọ̀ kan sọrọ̀, pe (844) 995-1752.

## Language Access Services:

### **It's important we treat you fairly**

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, P.O. Box 27401, Mail Drop VA2002-N160, Richmond, VA 23279. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## Summary of Benefits

Anthem Dental Essential Choice

City of Canton

Anthem Dental Complete Network

## Appendix I

### WELCOME TO YOUR DENTAL PLAN!

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. So, don't skimp on your dental care, good oral care can mean better overall health!

#### Powerful and easily accessible member tools.

- **Ask a Hygienist:** Dental members can simply email their dental questions to a team of licensed dental professionals who in turn will respond in about 24 hours.
- **Dental Health Risk Assessment:** We want our dental members to better understand their oral health and their risk factors for tooth decay, gum disease and oral cancer. This easy to use online tool can help them do this.
- **Dental Care Cost Estimator:** In order to help our dental member better understand the cost of their dental care, we offer access to a user-friendly, web-based tool that provides estimates on common dental procedures and treatments when using a network dentist.
- **More Capabilities:** With our latest mobile application, members can find a network dentist as well as view their claims. Our application is available for both Android and Apple phones.

#### Dentists in your plan network.

- You'll save money when you visit a dentist in your plan network because Anthem and the dentist have agreed on pricing for covered services. Dentists who are not in your plan network have not agreed to pricing, and may bill you for the difference between what Anthem pays them and what the dentist usually charges.

- To find a dentist by name or location, go to [anthem.com](http://anthem.com) or call dental customer service at the number listed on the back of your ID card.

#### Ready to use your dental benefits?

- Choose a dentist from the network
- Make an appointment
- Show the office staff your member ID card
- Pay any deductible or copay that is part of your plan

#### Need to contact us?

- See the back of your ID card for who to call, write or email.

#### Your dental benefits at a glance

The following benefit summary outlines how your dental plan works and provides you with a quick reference of your dental plan benefits. For complete coverage details, please refer to your policy.

		In-Network		Out-of-Network	
<b>Annual Benefit Maximum</b>	Calendar Year	\$1,500 Yes	\$1,500 Yes		
• Per insured person					
<b>D&amp;P applies to Annual Maximum</b>		No/No	No/No		
<b>Annual Maximum Carryover / Carry in</b>					
<b>Orthodontic Lifetime Benefit Maximum</b>					
<b>Individual Lifetime Deductible Orthodontics</b>		\$100 Per Individual	\$100 Per Individual		
• Per eligible insured person		\$1,500	\$1,500		
<b>Annual Deductible (Does not apply to Orthodontic Services)</b>	Calendar Year				
• Per insured person/Family maximum		\$25/2X Individual	\$25/2X Individual		
<b>Deductible Waived for Diagnostic/Preventive Services</b>		Yes	Yes		
<b>Out-of-Network Reimbursement:</b>		90th percentile			

Dental Services	In-Network Anthem Pays:	Out-of-Network Anthem Pays:	Waiting Period
<b>Diagnostic and Preventive Services</b> <ul style="list-style-type: none"> <li>• Periodic oral exam 2 per 12 months</li> <li>• Teeth cleaning (prophylaxis) 2 per 12 months; w/o periodontal maintenance</li> <li>• Bitewing X-rays: 2 sets per 12 months</li> <li>• Full-mouth or Panoramic X-rays: 1 per 36 months</li> <li>• Fluoride application: 1 per 12 months through age 18 1 per 60 months; through age 18</li> <li>• Sealants 1 per 60 months; through age 18</li> </ul>	100% Coinsurance	100% Coinsurance	No Waiting Period
<b>Basic Services</b> <ul style="list-style-type: none"> <li>• Consultation (second opinion) 1 per 12 months</li> <li>• Amalgam (silver-colored) Filling 1 per tooth per 24 months</li> <li>• Composite (tooth-colored) Filling 1 per tooth per 24 months</li> <li>• posterior (back) fillings covered as composites</li> <li>• Brush Biopsy (cancer test) Covered; 1 per 12 months; all ages</li> <li>• Space Maintainers 1 per lifetime through age 14; posterior teeth</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Endodontics (Non-Surgical)</b> <ul style="list-style-type: none"> <li>• Root Canal 1 per tooth per lifetime</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Endodontics (Surgical)</b> <ul style="list-style-type: none"> <li>• Apicoectomy and apexification 1 per tooth per lifetime</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Periodontics (Non-Surgical)</b> <ul style="list-style-type: none"> <li>• Periodontal Maintenance 2 per 12 months; w/o teeth cleaning</li> <li>• Scaling and root planing 1 per quadrant per 24 months</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Periodontics (Surgical)</b> <ul style="list-style-type: none"> <li>• Periodontal Surgery (osseous, gingivectomy, graft procedures) 1 per quadrant per 36 months</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Oral Surgery (Simple)</b> <ul style="list-style-type: none"> <li>• Simple Extractions 1 per tooth per lifetime</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Oral Surgery (Complex)</b> <ul style="list-style-type: none"> <li>• Surgical Extractions 1 per tooth per lifetime</li> </ul>	80% Coinsurance	80% Coinsurance	No Waiting Period
<b>Major (Restorative) Services</b> <ul style="list-style-type: none"> <li>• Crowns, onlays, veneers 1 per tooth per 60 months</li> <li>• Cosmetic teeth whitening Not Covered</li> </ul>	50% Coinsurance	50% Coinsurance	No Waiting Period
<b>Temporomandibular Joint Disorder (TMJ)</b> <ul style="list-style-type: none"> <li>• X-rays, splints, and surgical procedures Not Covered</li> <li>• including arthroscopy and orthotic devices Not Covered</li> </ul>	Not Covered	Not Covered	N/A
<b>Prostodontics</b> <ul style="list-style-type: none"> <li>• Dentures and bridges 1 per tooth per 60 months</li> <li>• Dental Implants Not Covered</li> </ul>	50% Coinsurance	50% Coinsurance	No Waiting Period
<b>Prostodontic Repairs/Adjustments</b> <ul style="list-style-type: none"> <li>• Crown, denture, bridge repairs 1 per 12 months; 6 months after placement</li> <li>• Denture and bridge adjustments: 2 per 12 months; 6 months after placement</li> </ul>	50% Coinsurance	50% Coinsurance	No Waiting Period
<b>Orthodontic Services</b> <ul style="list-style-type: none"> <li>• Dependent Children Only*</li> </ul>	50% Coinsurance	50% Coinsurance	No Waiting Periods

\*Child orthodontic runs through age 18. This means that the child must have been banded prior to their 19th birthday in order to receive coverage.



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## Additional Services and Programs

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### Anthem Whole Health Connection - Dental®

- For members with certain health conditions, additional dental benefits are available without a deductible or waiting periods. Eligible services are paid at 100% and won't reduce your coverage year annual maximum (if applicable)

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### Accidental Dental Injury Benefit

- Provides members 100% coverage for accidental injuries to teeth up to the coverage year annual maximum (if applicable). No deductibles, member coinsurance, or waiting periods apply

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### Extension of Benefits

- Following termination of coverage, members are provided up to 60 days to complete treatment started prior to their termination of coverage under the plan and eligible services will be covered

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### International Emergency Dental Program

- Provides emergency dental benefits while working or traveling abroad from licensed, English-speaking dentists. Eligible covered services will be paid 100% with no deductibles, member coinsurance, or waiting periods and won't reduce the member coverage year annual maximum (if applicable)

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## Additional Limitations & Exclusions

**Below is a partial listing of non-covered services under your dental plan. Please see your policy for a full list.**

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**Services provided before or after the term of this coverage** - Services received before your effective date or after your coverage ends, unless otherwise specified in the dental plan certificate

**Orthodontics** (unless included as part of your dental plan benefits) including orthodontic braces, appliances and all related services

**Cosmetic dentistry** (unless included as part of your dental plan benefits) provided by dentists solely for the purpose of improving the appearance of the tooth when tooth structure and function are satisfactory and no pathologic conditions (cavities) exist

**Drugs and medications** including intravenous conscious sedation, IV sedation and general anesthesia when performed with nonsurgical dental care

**Analgesia, analgesic agents, and anxiolysis nitrous oxide**, therapeutic drug injections, medicines or drugs for nonsurgical or surgical dental care except that intravenous conscious sedation is eligible as a separate benefit when performed in conjunction with complex surgical services.

**Waiting periods** for endodontic, periodontic and oral surgery services may differ from other Basic Services or Major Services under the same dental plan.

Missing tooth clause of 24 months applies for the replacement of congenitally missing teeth or teeth lost prior to the coverage effective date for this plan

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This is not a contract; it is a partial listing of benefits and services. All covered services are subject to the conditions, limitations, exclusions, terms and provisions of your employee benefits booklet. In the event of a discrepancy between the information in this summary and the employee booklet, the employee booklet will prevail.

# Appendix I

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 02/01/2024 – 1/31/2025

## CITY OF CANTON


Coverage for: Individual/Family Plan Type: Prescription Plan



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 1-800-344-8858 / [www.aultcare.com](http://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 by calling AultCare at 1-800-344-8858 to request a copy, or online at [www.aultcare.com](http://www.aultcare.com).

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	Generally, you must pay all of the costs from <a href="#">providers</a> up to the calendar year <a href="#">deductible</a> amount before this plan begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Prescription drugs</a> are covered – there is no deductible on this plan.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> (medical/ <a href="#">prescription drugs</a> ): \$1,350 Individual /\$2,700 Family; Once met, additional <a href="#">Out-of-Pocket (Prescription Drug copayments only)</a> : \$5,000 Individual / \$10,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a calendar year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , cost differences between generic and brand drugs when you or your physician request a brand drug be dispensed when a generic is available, Prescription medication coupon, discount, or other manufacturer assistance programs for	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

Important Questions	Answers	Why This Matters:
	Specialty or other qualified medications, and health care this <a href="#">plan</a> doesn't cover.	
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. For a list of <a href="#">network providers</a> : see <a href="http://www.aultcare.com">www.aultcare.com</a> or call 1-800-344-8858.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	Not covered	Not covered	
	<a href="#">Specialist</a> visit	Not covered	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	Not covered	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Not covered	Not covered	
	Imaging (CT/PET scans, MRIs)	Not covered	Not covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.aultcare.com">www.aultcare.com</a>  This plan follows the Commercial Formulary.	Generic drugs	<b>Retail 1-30 day supply:</b> \$5 <a href="#">copayment</a> <b>Retail 31-90 day supply:</b> \$15 <a href="#">copayment</a> <b>Mail Order:</b> \$10 <a href="#">copayment</a>		<p><a href="#">Deductible</a> does not apply to <a href="#">prescription drugs</a>. Once the <a href="#">network</a> medical/prescription <a href="#">out-of-pocket limit</a> is reached, the additional <a href="#">Prescription Drug Out-of-Pocket</a> will apply. <a href="#">Copayments</a> will track toward the additional <a href="#">Prescription Drug Out-of-Pocket limit</a> of \$5,000 Individual / \$10,000 Family. Once the additional <a href="#">prescription drug out-of-pocket limit</a> is reached, the <a href="#">copayment</a> is \$0.</p> <p>You may obtain up to a 90-day supply of <a href="#">prescription drugs</a> at the retail pharmacy or through the mail order program.</p> <p>Specialty Medications must be obtained from AultCare's Preferred Specialty pharmacies.</p> <p>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>.</p>
	Preferred brand drugs	<b>Retail 1-30 day supply:</b> \$20 <a href="#">copayment</a> <b>Retail 31-90 day supply:</b> \$60 <a href="#">copayment</a> <b>Mail Order:</b> \$40 <a href="#">copayment</a>		
	Non-preferred brand drugs	<b>Retail 1-30 day supply:</b> \$35 <a href="#">copayment</a> <b>Retail 31-90 day supply:</b> \$105 <a href="#">copayment</a> <b>Mail Order:</b> \$70 <a href="#">copayment</a>		

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.aultcare.com](http://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)	
				<p>Certain preventive medications may be covered at 100%, with no cost to you.</p> <p>Certain classes of medications require <a href="#">Preauthorization</a> or Step Therapy.</p> <p>For a complete list of these medications and programs, visit the AultCare website at <a href="http://www.aultcare.com">www.aultcare.com</a>.</p>
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	Not covered	Not covered	
	Physician/surgeon fees	Not covered	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	Not covered	Not covered	
	<a href="#">Emergency medical transportation</a>	Not covered	Not covered	
	<a href="#">Urgent care</a>	Not covered	Not covered	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	Not covered	Not covered	
	Physician/surgeon fees	Not covered	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Not covered	Not covered	
	Inpatient services	Not covered	Not covered	
<b>If you are pregnant</b>	Office visits	Not covered	Not covered	
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.aultcare.com](http://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)	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	Not covered	Not covered	
	<a href="#">Rehabilitation services</a>	Not covered	Not covered	
	<a href="#">Habilitation services</a>	Not covered	Not covered	
	<a href="#">Skilled nursing care</a>	Not covered	Not covered	
	<a href="#">Durable medical equipment</a>	Not covered	Not covered	
	<a href="#">Hospice services</a>	Not covered	Not covered	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

**Excluded Services & Other Covered Services:**

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered, as allowed under applicable law)</li> <li>• Acupuncture</li> <li>• Bariatric Surgery</li> <li>• Chiropractic Care</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care</li> <li>• Habilitation Services</li> <li>• Hearing Aids (up to \$3,000 per every 4 years)</li> <li>• Infertility Treatment</li> <li>• Long Term Care</li> </ul>	<ul style="list-style-type: none"> <li>• Non-Emergency care when traveling outside the U.S.</li> <li>• Private Duty Nursing</li> <li>• Routine Eye Care</li> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

**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). Other coverage options may be available to you too, including buying individual insurance coverage through the Health

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

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 AultCare at 1-800-344-8858 or 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 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:**

[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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist coinsurance</a>	n/a
■ Hospital (facility) <a href="#">coinsurance</a>	n/a
■ Other <a href="#">coinsurance</a>	n/a

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>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments (2 Generic RX)</a>	\$10
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,690
<b>The total Peg would pay is</b>	<b>\$12,700</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist coinsurance</a>	n/a
■ Hospital (facility) <a href="#">coinsurance</a>	n/a
■ Other <a href="#">coinsurance</a>	n/a

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>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments (31 Generic, 13 Brand RX)</a>	\$365
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,235
<b>The total Joe would pay is</b>	<b>\$5,600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist coinsurance</a>	n/a
■ Hospital (facility) <a href="#">coinsurance</a>	n/a
■ Other <a href="#">coinsurance</a>	n/a

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>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments (1 Generic RX)</a>	\$5
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,795
<b>The total Mia would pay is</b>	<b>\$2,800</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: 711 Outside Stark County: 711**

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### 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 : 711 Fuera del condado de Stark : 711**

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### 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： 711 斯塔克縣外： 711**。

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### 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: 711 Außerhalb von Stark County : 711**

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### Arabic

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

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### 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 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 griegie, 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.**

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### 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, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имете 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.**

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### 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 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**

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

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## 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.

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## 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.

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## 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**.

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## 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ぬ場合があります。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 : 711 スターク郡の外 : 711** までお電話ください。

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## 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 met 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 : 711 Buiten Stark County : 711**.

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## 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 : 711 Поза Старка County : 711**.

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## Romanian

Română  
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**Appendix I**



**Employee Benefits Vision Renewal Effective Date: 02/01/2023  
City of Canton**

Plan Summary		VSP	
		Network	Non-Network
<u>Copayments</u>	Exam	\$10 copay then Routine covered 100%/Retinal no more than a \$39 copay	Up to a \$45 reimbursement
	Materials		\$25 copay
<u>Frequency</u>	Exam	12 Months	
	Lenses	12 Months	
	Frames	24 Months	
	Contacts Lenses (In lieu of frames & lenses)	12 Months	
<u>Benefits after copay</u>	Eye Exam	covered after copay	Up to \$30
	Single Vision Lenses	covered after copay	Up to \$30
	Bifocal Lenses	covered after copay	Up to \$50
	Trifocal Lenses	covered after copay	Up to \$65
	Lenticular Lenses	covered after copay	Up to \$100
	Frames	\$130 allowance; 20% off balance covered/\$60 copay max \$130 allowance	Up to \$70
	Contacts, medically necessary		Up to \$210
	Contacts (In lieu of frames & lenses)		Up to \$105

Appendix I

2025 Sample Plans  
City of Canton

Services & Fees	PPO With Co-Pays		High Deductible Health Plan (HDHP) w/HSA	
	In-Network	Out of Network	In-Network	Out of Network
Deductible Single/Family	\$700/\$1,400	\$1,000/\$2,000	\$1,600/\$3,200	\$3,200/\$6,400
Co-Insurance	20%	30%	10%	30%
Out of Pocket Max Single/Family	\$6,350/\$12,700	\$12,700/\$25,400	\$3000 / \$6000	\$6,000 / \$12,000
Office Visits				
Primary or Urgent Care	\$20	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Gynecological Visits	\$30			
Specialist	\$30			
Preventive Care	100%	Subject to Deductible/Coinsurance	100%	Subject to Deductible/Coinsurance
Urgent Care	\$75	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Emergency Room Copay	\$250 Copay	\$250 Copay	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Inpatient Care	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Outpatient Surgery	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Outpatient X-ray, Other Diagnostic	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Lab	\$20	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Durable Medical	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance	Subject to Deductible/Coinsurance
Pharmacy Retail		Not Covered	Subject to Deductible/Coinsurance	Not Covered
Generic Drugs	\$5			
Brand Drugs (Preferred)	\$20			
Brand Drugs (Non-Preferred)	\$35			
Specialty Drugs (Preferred)	10% up to \$250			
Pharmacy 90-Day				
Generic Drugs	\$10			
Brand Drugs (Preferred)	\$40			
Brand Drugs (Non-Preferred)	\$70			
Specialty Drugs (Preferred)	N/A			

2025 Rates

Medical, RX, Dental & Vision Rates 3-Tier

	PPO With Co-Pays	High Deductible Health Plan (HDHP) w/HSA
	Single	\$55.00
Employee +1	\$85.00	\$26.75
Family	\$110.00	\$34.75