Hospital Authority of Valdosta and Lowndes County, Georgia Employee Health Benefit Plan

Coverage for: Single + Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, www.mycoresource.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.cciio.cms.gov or call 1-877-267-2323 extension 61565 to request a copy. Questions: Call 1-855-274-8709 or visit us at www.mycoresource.com for more information, including a copy of your plan's plan document and summary plan description.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For SGMC providers: $500/individual or $1,000/family per calendar year. For preferred providers: $2,000/individual or $4,000/family per calendar year. For non-preferred providers: $4,000/individual or $8,000/family, per calendar year.	Generally, you must pay all of the costs from providers up to the 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. Prescription drugs, emergency treatment in an emergency room, SGMC inpatient and outpatient hospital, SGMC diagnostic tests and outpatient surgery, and the following services by an SGMC or preferred provider: preventive care, inpatient and office visits, imaging tests, rehabilitation services, urgent care, outpatient surgery (facility) and routine maternity services.	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 SGMC providers and preferred providers combined: $6,600/individual or $13,200/family. For nonpreferred providers: unlimited.	The out-of-pocket limit is the most you could pay in a 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?	Non-preferred deductible and coinsurance, penalties for failure to obtain pre-authorization for services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bcbsga.com or call 1-800-810-2583 for a list of network providers.	You pay the least if you use a provider in South Georgia Medical Center (SGMC). You pay more if you use a provider in Blue Cross Anthem GA. 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 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
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay less)	Nonpreferred 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	$30 copay/visit (deductible does not apply)	$30 copay/visit (deductible does not apply)	50% coinsurance	Nonpreferred providers are limited to the usual and customary allowance.
	Specialist visit	$60 copay/visit (deductible does not apply)	$60 copay/visit (deductible does not apply)	50% coinsurance	Nonpreferred providers are limited to the usual and customary allowance.
	Preventive care/screening/ immunization	No charge (deductible does not apply)	No charge (deductible does not apply)	Not Covered	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay less)	Nonpreferred Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	$30 copay then 10% coinsurance (deductible does not apply)	20% coinsurance	50% coinsurance	Benefit includes EKGs. Nonpreferred providers are limited to the usual and customary allowance.
	Imaging (CT/PET scans, MRIs)	$200 copay then 10% coinsurance (deductible does not apply)	$400 copay then 20% coinsurance (deductible does not apply)	50% coinsurance	Not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.envisionrx.com or call 1-800-361-4542.	Generic drugs	$10 copay for 34-day supply retail (60-day for maintenance drugs) and for Walmart Drug Listing $4 copay for 34-day supply and $10 for 90-day supply of maintenance drugs	$15 copay for 34-day supply retail	Not Covered	Copay does not apply to preventive drugs required by the Affordable Care Act.
	Preferred brand drugs	20% with minimum $25 and maximum $100 copay for 34-day supply retail or 60-day for maintenance drugs	25% with minimum $30 and maximum $100 copay for 34-day supply retail	Not Covered	
	Non-preferred brand drugs	20% with minimum $40 and maximum $100 copay for 34-day supply retail or 60-day for maintenance drugs	25% with minimum $45 and maximum $100 copay for 34-day supply retail	Not Covered	
	Specialty drugs	Same as above	Not Covered	Not Covered	Limited to a 34-day supply

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay less)	Nonpreferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay then 10% coinsurance (deductible does not apply)	$1,000 copay then 20% coinsurance (deductible does not apply)	50% coinsurance	Some surgeries not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
	Physician/surgeon fees	Office $100 copay then 20% coinsurance; Other 20% coinsurance (deductible does not apply)	Office $100 copay then 20% coinsurance; Other 20% coinsurance (deductible does not apply if at an SGMC facility)	Office Not Covered; Other 50% coinsurance	Nonpreferred providers are limited to the usual and customary allowance.
If you need immediate medical attention	Emergency room care	$250 copay/visit (deductible does not apply)	$250 copay/visit (deductible does not apply)	$250 copay/visit (deductible does not apply)	Copay waived if admitted within 24 hours. Nonpreferred providers are limited to the usual and customary allowance.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	Nonpreferred providers are limited to the usual and customary allowance.
	Urgent care	$20 copay/visit (deductible does not apply)	$75 copay/visit (deductible does not apply)	50% coinsurance	Nonpreferred providers are limited to the usual and customary allowance.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 copay /day (limit 5 days) then 10% coinsurance (deductible does not apply)	20% coinsurance	50% coinsurance	Not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
	Physician/surgeon fees	20% coinsurance (deductible does not apply)	20% coinsurance (deductible does not apply if at an SGMC facility)	50% coinsurance	Nonpreferred providers are limited to the usual and customary allowance.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay less)	Nonpreferred Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay/office visit or clinic visit (deductible does not apply); 10% coinsurance for other outpatient services	$30 copay/office visit or clinic visit (deductible does not apply); 20% coinsurance for other outpatient services	50% coinsurance	Some services not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
	Inpatient services	Facility $100 copay /day (limit 5 days) then 10% coinsurance (deductible does not apply); Physician 20% coinsurance (deductible does not apply)	20% coinsurance (deductible does not apply if at an SGMC facility)	50% coinsurance	Not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
If you are pregnant	Office visits	No charge (deductible does not apply)	No charge (deductible does not apply)	50% coinsurance	Dependent daughters are not covered for this benefit. Cost sharing does not apply for preventive services. Nonpreferred providers are limited to the usual and customary allowance. Depending on the type of services, a copay, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	Not Available	20% coinsurance (deductible does not apply if at an SGMC facility)	50% coinsurance	
	Childbirth/delivery facility services	$300 copay then 10% coinsurance (deductible does not apply)	$1,000 copay then 20% coinsurance (deductible does not apply)	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		SGMC Provider (You will pay the least)	Anthem GA Preferred Provider (You will pay less)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	50% coinsurance	Not covered unless pre-certified. Limited to 120 visits per calendar year. Nonpreferred providers are limited to the usual and customary allowance.
	Rehabilitation services	$30 copay/visit (deductible does not apply)	$55 copay/visit (deductible does not apply)	50% coinsurance	Medical necessity review required for >30 visits per calendar year. Nonpreferred providers are limited to the usual and customary allowance.
	Habilitation services	10% coinsurance	20% coinsurance	50% coinsurance	Birth through age 18. Medical necessity review required for >20 visits per calendar year. Nonpreferred providers are limited to the usual and customary allowance.
	Skilled nursing care	10% coinsurance	20% coinsurance	50% coinsurance	Not covered unless pre-certified. Limited to 90 days per calendar year. Nonpreferred providers are limited to the usual and customary allowance.
	Durable medical equipment	10% coinsurance	20% coinsurance	50% coinsurance	Equipment >$500 not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
	Hospice services	10% coinsurance	20% coinsurance	50% coinsurance	Inpatient not covered unless pre-certified. Nonpreferred providers are limited to the usual and customary allowance.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not Covered	Limited to children through age 18.
	Children's glasses	Not Covered	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None.

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.)		
• Acupuncture; • Bariatric surgery; • Cosmetic surgery; • Dental care;	• Habilitation services; • Infertility treatment; • Long-term care; • Non-emergency care when traveling outside the U.S.;	• Private-duty nursing (unless part of home health care); • Routine eye care (Adult); • Routine foot care, and • Weight-loss programs.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Chiropractic care; and	• Hearing aids (children 18 years or younger, limit one per ear, up to $3,000, every 48 months)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or 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 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: Contact CoreSource at 1-855-274-8709 or visit us at www.mycoresource.com.

Does this plan provide Minimum Essential Coverage? Yes

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

Does this plan meet 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 1-855-274-8709.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$500
Specialist	$60
Hospital (facility)	10%
Other	10%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$298
Coinsurance	$1,479
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,337

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

The plan's overall deductible	$500
Specialist	$60
Hospital (facility)	10%
Other	10%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$700
Coinsurance	$902
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,158

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

The plan's overall deductible	$500
Specialist	$60
Hospital (facility)	10%
Other	10%

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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$577
Coinsurance	$86
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,163

The plan would be responsible for the other costs of these EXAMPLE covered services.

NOTICE OF NONDISCRIMINATION

Discrimination is Against the Law

Hospital Authority of Valdosta and Lowndes County, Georgia complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Hospital Authority of Valdosta and Lowndes County, Georgia does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Hospital Authority of Valdosta and Lowndes County, Georgia:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Johnny Ball.

If you believe that Hospital Authority of Valdosta and Lowndes County, Georgia has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Johnny Ball
2501 N. Patterson Street
Valdosta, Georgia 31602
Telephone number: 229-259-4125
Email: Johnny.Ball@sgmc.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Johnny Ball is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

ATTENTION: If you speak a different language, language assistance services are available to you free of charge. Call 1-855-274-8709.

Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-274-8709.

繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-274-8709.

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-274-8709.

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-274-8709 번으로 전화해 주십시오.

Tagalog (Tagalog – Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-274-8709.

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-274-8709.

العربيـــــة (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-558-472-9078 (رقم هاتف الصم والبكم:.

Kreyòl Ayisyen (French Creole)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-274-8709.

Français (French)

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-274-8709.

Polski (Polish)

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-274-8709.

Português (Portuguese)

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-274-8709.

Italiano (Italian)

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-274-8709.

Deutsch (German)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-274-8709.

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-274-8709 まで、お電話にてご連絡ください。

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-274-8709 تماس بگیرید.

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-274-8709 पर कॉल करें।

Հայերեն (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-274-8709.

ગુજરાતી (Gujarati)

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-274-8709.

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-274-8709.

اُردُو (Urdu)

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-274-8709.

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-274-8709.។

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-274-8709 'ਤੇ ਕਾਲ ਕਰੋ।

বাংলা (Bengali)

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 1-855-274-8709 ।

אידיש (Yiddish)

- אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-855-274-8709.

አማርኛ (Amharic)

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-274-8709.

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-274-8709.

Oroomiffa (Oromo)

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-274-8709.

Ilokano (Ilocano)

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-855-274-8709.

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-274-8709.

Shqip (Albanian)

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-274-8709.

Srpsko-hrvatski (Serbo-Croatian)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-274-8709.

Українська (Ukrainian)

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-855-274-8709.

नेपाली (Nepali)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-855-274-8709. ।

Nederlands (Dutch)

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-855-274-8709.

unD (Karen)

ဟ်သူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်ဒၤယိ, နမၤန့ါ ကျိာ်ဒၤတ်မၤစၢၤလ၊ တလၫ်ဘူဉ်လၫ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-855-274-8709.

Gagana fa'a Sāmoa (Samoan)

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-855-274-8709.

Kajin Ṃajōl (Marshallese)

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-855-274-8709.

Română (Romanian)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-855-274-8709.

Foosun Chuuk (Trukese)

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-855-274-8709.

Tonga (Tongan)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea teke lava 'o ma'u ia. Telefoni mai 1-855-274-8709.

Bisaya (Bisayan)

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1-855-274-8709.

Ikirundi (Bantu – Kirundi)

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-855-274-8709.

Kiswahili (Swahili)

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-855-274-8709.

Bahasa Indonesia (Indonesian)

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-855-274-8709.

Türkçe (Turkish)

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-855-274-8709 irtibat numaralarını arayın.

ىكـورد (Kurdish)

ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە بکە.1-855-274-8709

తెలుగు (Teluga)

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. 1-855-274-8709 కు కాల్ చేయండి.

Thuɔŋjaŋ (Nilotic – Dinka)

PIƆ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-855-274-8709.

Norsk (Norwegian)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-855-274-8709.

Català (Catalan)

ATENCIÓ: Si parleu Català, teniu disponible un servei d”ajuda lingüística sense cap càrrec. Truqueu al 1-855-274-8709.

λληνικά (Greek)

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-855-274-8709.

Igbo asusu (Ibo)

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-855-274-8709.

èdè Yorùbá (Yoruba)

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-855-274-8709.

Lokaiahn Pohnpei (Pohnpeian)

Ni songen mwohmw ohte, komw pahn sohte anahne kawehwe mesen nting me koatoantoal kan ahpw wasa me ntingie [Lokaiahn Pohnpei] komw kalangan oh ntingidieng ni lokaiahn Pohnpei. Call 1-855-274-8709.

Deitsch (Pennsylvania Dutch)

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-855-274-8709.

ho‘okomo ‘ōlelo (Hawaiian)

E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo [ho‘okomo ‘ōlelo], loa‘a ke kōkua manuahi iā ‘oe. E kelepona iā 1-855-274-8709.

Adamawa (Fulfulde)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-855-274-8709.

tsalagi gawonihisdi (Cherokee)

Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-855-274-8709.

I linguahén Chamoru (Chamorro)

ATENSIÓN: Yanggen un tungó [I linguahén Chamoru], i setbision linguahé gaige para hagu dibatde ha . Agang I 1-855-274-8709.

ܣܘܪܝܬ (Assyrian)

ܙܘܗܪܐ: ܐܢ ܐܝܬܘܟܘܢ ܟܐ ܡܡܠܠܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܬܚܘ ܝܠܘܟܘܢ ܕܡܫܬܡܫܝܬܘܢ ܒܚܠܡܬܐ ܕܥܘܕܪܢܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ
1-855-274-8709.

(Burmese)

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-855-274-8709 သို့ ခေါ်ဆိုပါ။

Diné Bizaad (Navajo)

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih:
1-855-274-8709.

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ (Bassa)

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́in m̀ gbo kpáa. Ɖá 1-855-274-8709.

Chahta (Choctaw)

ANOMPA PA̱ PISAH: [Chahta] makilla ish anompoli hokma̱, kvna hosh Nahollo Anompa ya̱ pipilla hosh chi̱ tosholahinla. Atoko̱, hattak yvmma̱ im anompoli chi bvnnakmvt, holhtina pa̱ pa̱yah: 1-855-274-8709.