This is only a summary. If you want more detail about your coverage and costs, please refer to your 2017 Annual Benefits Enrollment materials and contact information for your medical plan, as well as the Bank of America Health & Insurance Summary Plan Description and subsequent updates, located on My Benefits Resources at mybenefitsresources.bankofamerica.com or by calling the Global HR Service Center at 1-800-556-6044.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**In-Network** / **Out-of-Network** Individual: $500 / $1,000 Family: $1,000 / $2,000 The **deductible** doesn't apply to in-network preventive care. Prescription drug copayments and coinsurance amounts do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. The **deductible** starts over January 1st of each calendar year. See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet separate **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, based on whether you use in-network or out-of-network providers: **In-Network** / **Out-of-Network** Individual: $2,000 / $4,000 Family: $4,000 / $8,000	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one calendar year) for your share of the cost of covered services. This limit helps you plan for health care expenses. It includes the deductible and medical and prescription drug copayments and coinsurance amounts.
What is not included in the out-of-pocket limit?	Premiums, pre-authorization penalty amounts, balance-billed 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**.

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Important Questions	Answers	Why this Matters:
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 3 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.aetna.com/bankofamerica or call **1-877-444-1012** for a list of in-network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 3 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes. Refer to the Bank of America Health & Insurance Summary Plan Description and subsequent updates for details.	Some of the services this plan doesn't cover are listed on page 5. See your Bank of America Health & Insurance Summary Plan Description and subsequent updates for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copayment/visit	40%, after deductible	——————none——————
	Specialist visit	$25 copayment/visit	40%, after deductible	——————none——————
	Other practitioner office visit	20%, after deductible, for chiropractor and acupuncture	40%, after deductible, for chiropractor and acupuncture	Chiropractor limited to 20 visits/calendar year Acupuncture only covered in lieu of anesthesia for a covered surgery
	Preventive care/screening/immunization	No charge	40%, after deductible	2 physical exams/1 GYN exam with pap smear/calendar year
If you have a test	Diagnostic test (x-ray, blood work)	20%, after deductible	40%, after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20%, after deductible	40%, after deductible	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com **or call 1-800-701-5833**	Generic drugs (copayment per prescription)	$5 for 30 day supply; $10 for 90 day supply	40% of CVS Caremark discounted rate	Covers up to a 30-day supply (retail prescription); up to a 90-day supply (mail order prescription and participating Retail 90 pharmacies). Certain contraceptives may be covered at 100% in-network. For maintenance drugs, there may be limit to the number of refills available through your retail pharmacy. Please contact CVS Caremark for further details.
	Preferred brand drugs (copayment per prescription)	$25 for 30 day supply; $50 for 90 day supply	40% of CVS Caremark discounted rate	
	Non-preferred brand drugs (copayment per prescription)	$50 for 30 day supply; $100 for 90 day supply	40% of CVS Caremark discounted rate	
	Specialty drugs, including Specialty fertility drugs (copayment per prescription)	Applicable generic or brand copay /retail only through Caremark Specialty Pharmacy	Not covered	Covers up to a 30-day supply only through Caremark Specialty Pharmacy; prior authorization may be required.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20%, after deductible	40%, after deductible	——————none——————
	Physician/surgeon fees	20%, after deductible	40%, after deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20%, after deductible	20%, after deductible	No coverage for non-emergency care
	Emergency medical transportation	20%, after deductible	20%, after deductible	No coverage for non-emergency transportation unless pre-authorized
	Urgent care	$50 copayment/visit	40%, after deductible	No coverage for non-urgent care
If you have a hospital stay	Facility fee (e.g., hospital room)	20%, after deductible	40%, after deductible	Out-of-network charges subject to $500 penalty if not pre-authorized
	Physician/surgeon fee	20%, after deductible	40%, after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copayment/visit	40%, after deductible	Out-of-network charges for inpatient mental/behavioral health and substance use disorder treatment are subject to a $500 penalty if not pre-authorized
	Mental/Behavioral health inpatient services	20%, after deductible	40%, after deductible	
	Substance use disorder outpatient services	$15 copayment/visit	40%, after deductible	
	Substance use disorder inpatient services	20%, after deductible	40%, after deductible	
If you are pregnant	Prenatal and postnatal care	Prenatal (OB/GYN) office visits: No charge; all other specialists and office services: $25 copayment Postnatal office visits: Copayment applies	40%, after deductible	————————none————————
	Delivery and all inpatient services	20%, after deductible	40%, after deductible	————————none————————
If you need help recovering or have other special health needs	Home health care	20%, after deductible	40%, after deductible	Limited to 120 visits/calendar year/combined in-/out-of-network
	Skilled nursing care	20%, after deductible	40%, after deductible	Limited to 100 days/calendar year combined in-/out-of-network
	Rehabilitation services	20%, after deductible	40%, after deductible	Limited to 90 visits/calendar year/combined in-/out-of-network; all rehabilitation and habilitation visits (physical, occupational and speech therapy) count toward this limit
	Habilitation services	20%, after deductible	40%, after deductible	
	Durable medical equipment			
	Hospice service			

Common Medical Event	Services You May Need	Your cost if you use an In-Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20%, after deductible	20%, after deductible	No coverage for non-emergency care
	Emergency medical transportation	20%, after deductible	20%, after deductible	No coverage for non-emergency transportation unless pre-authorized
	Urgent care	$50 copayment/visit	40%, after deductible	No coverage for non-urgent care
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Covered under separate vision and dental plans
	Glasses	Not covered	Not covered	
	Dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery (unless deemed medically necessary or stated in the Summary Plan Description and subsequent updates)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Preventive hand and foot care
- Private-duty nursing
- Routine dental care
- Routine eye care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (only in lieu of anesthesia for a covered surgery)
- Bariatric surgery (In-network only)Chiropractor care (up to 20 visits/calendar year)
- Hearing aids (up to $3,000 every 24 months for participants under 18 years of age; every 36 months for participants age 18 and over)
- Infertility treatment (prior authorization required)

Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the Global HR Service Center at 1-800-556-6044. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Aetna at 1-877-444-1012, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

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

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-556-6044.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-556-6044.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-556-6044.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-556-6044.

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

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays**: $5,710
- **Patient pays**: $1,830

Sample care costs:

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

Patient pays:

Deductibles	$500
Copays	$10
Coinsurance	$1,170
Limits or exclusions	$150
Total	**$1,830**

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

- **Amount owed to providers:** $5,400
- **Plan pays**: $4,590
- **Patient pays**: $810

Sample care costs:

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

Patient pays:

Deductibles	$140
Copays	$590
Coinsurance	$0
Limits or exclusions	$80
Total	**$810**

Examples assume employee-only coverage in-network.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

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

What does a Coverage Example show?

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

Does the Coverage Example predict my own care needs?

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

Does the Coverage Example predict my future expenses?

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

Can I use Coverage Examples to compare plans?

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

Are there other costs I should consider when comparing plans?

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

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Bank of America Corporation complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Bank of America Corporation does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Bank of America Corporation:

- 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 Employee Relations.

If you believe that Bank of America Corporation 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: Employee Relations, NC1-021-09-03, 401 N. Tryon Street, Charlotte, NC 28255, **1.800.556.6044**, TTY: 711, 1-800-556-6044, FAX: 704.208.2986, Escalation_Team-Personnel@bankofamerica.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Employee Relations 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, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-556-6044 (TTY: 711, 1-800-556-6044).

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 1-800-556-6044 (TTY: 711, 1-800-556-6044)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-556-6044 (TTY: 711, 1-800-556-6044).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-556-6044 (TTY: 711, 1-800-556-6044) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-556-6044 (телетайп: 711, 1-800-556-6044).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-556-6044(رقم هاتف الصم والبكم: 1-800-556-6044, 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-556-6044 (ATS : 711, 1-800-556-6044).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-556-6044 (TTY: 711, 1-800-556-6044).

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。1-800-556-6044 (TTY: 711, 1-800-556-6044) まで、お電話にてご連絡ください。

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

تماس بگیرید 1-800-556-6044 (TTY: 711, 1-800-556-6044) **ب فراهم می باشد.** .

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-556-6044 (TTY: 711, 1-800-556-6044) पर कॉल करें।.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության.

.ծառայություններ: Զանգահարեք 1-800-556-6044 (TTY (հեռատիպ)՝ 711, 1-800-556-6044):

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-556-6044 (TTY: 711, 1-800-556-6044).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-556-6044 (TTY: 711, 1-800-556-6044).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں1-800-556-6044 (TTY: 711, 1-800-556-6044).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-556-6044 (TTY: 711, 1-800-556-6044) ។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-556-6044 (TTY: 711, 1-800-556-6044) **'ਤੇ ਕਾਲ ਕਰੋ।**

লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-556-6044 (TTY: ১-800-556-6044 ।

אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-556-6044 (መስማት ለተሳናቸው: 711, 1-800-556-6044.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-556-6044 (TTY: 711, 1-800-556-6044).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-556-6044 (TTY: 711, 1-800-556-6044).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-556-6044 (TTY: 711, 1-800-556-6044).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-556-6044 (TTY: 711, 1-800-556-6044).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-556-6044 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711, 1-800-556-6044).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-556-6044 (телетайп: 711, 1-800-556-6044).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ। फोन गर्नुहोस् 1-800-556-6044(टिटिवाइ: 711, 1-800-556-6044)।

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှဲ် ကျိာ်အတ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး
1-800-556-6044 (TTY: 711, 1-800-556-6044)

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: 1-800-556-6044 (TTY: 711, 1-800-556-6044).

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-556-6044 (TTY: 711, 1-800-556-6044).

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 1-800-556-6044 (TTY: 711, 1-800-556-6044).

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 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-556-6044 (TTY: 711, 1-800-556-6044).

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 1-800-556-6044 (TTY: 711, 1-800-556-6044).

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 1-800-556-6044 (TTY: 711, 1-800-556-6044.

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 1-800-556-6044 (TTY: 711, 1-800-556-6044 irtibat numaralarını arayın.

ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 1-800-556-6044 1-800-556-6044 (TTY: 711, 1-800-556-6044 بکە.

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. 1-800-556-6044 (TTY: 711, 1-800-556-6044) కు కాల్ చేయండి.

PIɔ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 1-800-556-6044 (TTY: 711, 1-800-556-6044)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ATENCIÓ: Si parleu Català, teniu disponible un servei d”ajuda lingüística sense cap càrrec. Truqueu al 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-556-6044 (TTY: 711, 1-800-556-6044).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 1-800-556-6044 (TTY: 711, 1-800-556-6044).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 1-800-556-6044 (TTY: 711, 1-800-556-6044).

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 1-800-556-6044 (TTY: 711, 1-800-556-6044).

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-556-6044 (TTY: 711, 1-800-556-6044).

E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe.
E kelepona iā 1-800-556-6044 (TTY: 711, 1-800-556-6044).

MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-800-556-6044 (TTY: 711, 1-800-556-6044).

Hagsesda: iyuhno hyiwoniha tsalagi gawonihisdi. Call 1-800-556-6044 (TTY: 711, 1-800-556-6044)

ATENSIÓN: Yanggen un tungó I linguahén Chamoru, i setbision linguahé gaige para hagu dibatde ha . Agang I 1-800-556-6044 (TTY: 711, 1-800-556-6044).

ܙܘܗܪ̈ܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝܬܘܢ ܕܡܦܠܚܝܬܘܢ ܡܢ ܚܠܡܬ̈ܐ ܕܗܘܕܪ̈ܢܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ
1-800-556-6044 (TTY: 711, 1-800-556-6044)

သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။

ဖုန်းနံပါတ် 1-800-556-6044 (TTY: 711, 1-800-556-6044) သို့ ခေါ်ဆိုပါ။

D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-800-556-6044 (TTY: 711, 1-800-556-6044)

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ìn m̀ gbo kpáa. Ɖá 1-800-556-6044 (TTY: 711, 1-800-556-6044)

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: 1-800-556-6044 (TTY: 711, 1-800-556-6044).