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, please refer to your 2021 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 **800.556.6044.** 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 **https://www.healthcare.gov/sbc-glossary/** or call **800.556.6044** to request a copy.

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	Generally, you must pay all 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**. The **deductible** starts over January 1st of each calendar year.
Are there services covered before you meet your deductible?	Yes. **Preventive care** services, provider office visits, and prescription drugs are covered in-network before you meet your **deductible**.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers in-network **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?	**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 in a calendar year for covered services. It includes the **deductible** and medical and prescription drug **copayments** and **coinsurance** amounts. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the out-of-pocket limit?	**Premiums**, pre-authorization penalty amounts, **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**.
Will you pay less if you use a network provider?	Yes, see **www.anthem.com** or call **844.412.2976** for a list of network providers.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware, your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No.	You can see the **specialist** you choose without a **referral**.

All **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. The **copayments** do not apply to the **deductible**.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 **copayment**/office visit	40% **coinsurance**	——————none——————
	Specialist visit	$25 **copayment**/office visit	40% **coinsurance**	——————none——————
	Preventive care/screening/ immunization	No charge	40% **coinsurance**	2 physical exams/1 GYN exam with pap smear/calendar year. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your **plan** will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	40% **coinsurance**	Covered 100% if part of in-network office visit
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	——————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 800.701.5833**	Generic drugs	$5 **copayment** for 30-day supply; $10 **copayment** for 90-day supply; $0 **copayment for certain** preventive drugs, retail and mail	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	$25 **copayment** for 30-day supply; $50 **copayment** for 90-day supply, $0 copayment for certain **preventive** drugs, retail and mail	40% of CVS Caremark discounted rate	
	Non-preferred brand drugs	$50 **copayment** for 30-day supply; $100 **copayment** for 90-day supply, $0 copayment for certain **preventive** drugs, retail and mail	40% of CVS Caremark discounted rate	
	Specialty drugs, including Specialty fertility drugs	Applicable generic or brand **copayment**/retail only through Caremark Specialty Pharmacy, $0 copayment for certain **preventive** drugs	Not covered	Covers up to a 30-day supply only through Caremark Specialty Pharmacy; **preauthorization** may be required to obtain coverage.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	40% **coinsurance**	——————none——————
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	——————none——————
If you need immediate medical attention	Emergency room care	20% **coinsurance**	20% **coinsurance**	No coverage for non-**emergency** care
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	**Preauthorization** required for non-**emergency medical transportation** to obtain coverage
	Urgent care	$50 **copayment**/visit	40% **coinsurance**	No coverage for non-**urgent care**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	40% **coinsurance**	**Preauthorization** required out-of-network or benefits could be reduced by $500
	Physician/surgeon fee	20% **coinsurance**	40% **coinsurance**	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 **copayment**/visit/ professional; 20% **coinsurance**/facility	40% **coinsurance**	**Preauthorization** required out-of-network for inpatient and certain outpatient mental/ behavioral health and substance use disorder treatment or benefits could be reduced by $500
	Inpatient services	20% **coinsurance**	40% **coinsurance**	
If you are pregnant	Office visits	Prenatal (OB/GYN) office visits: No charge; all other specialists and office services: $25 **copayment** Postnatal office visits: **Copayment** applies	40% **coinsurance**	Cost sharing does not apply for **preventive services.** Depending on the type of services, **copayments** or **coinsurance** may apply. **Copayment** applies to the first visit to confirm pregnancy. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	20% **coinsurance**	40% **coinsurance**	——————none——————
	Childbirth/delivery facility services	20% **coinsurance**	40% **coinsurance**	——————none——————

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	40% **coinsurance**	Limited to 120 visits/calendar year/combined in-/out-of-network; **preauthorization** required to obtain coverage for in-network private duty nursing for terminal illness
	Rehabilitation services	20% **coinsurance**	40% **coinsurance**	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. These are subject to review for continued medical necessity after 25 visits.
	Habilitation services	20% **coinsurance**	40% **coinsurance**	
	Skilled nursing care	20% **coinsurance**	40% **coinsurance**	Limited to 100 days/calendar year combined in-/out-of-network; ; **preauthorization** required for out-of-network facility or benefits could be reduced by $500
	Durable medical equipment	20% **coinsurance**	40% **coinsurance**	——————none——————
	Hospice services	20% **coinsurance**	40% **coinsurance**	——————none——————
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Covered under separate vision and dental plans
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- 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.
- Private-duty nursing (unless in lieu of inpatient hospice after preauthorization)
- Routine dental care (Adult)
- Routine foot care
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture (when **medically necessary**, up to 20 visits/calendar year/combined in- and out-of-network)
- Bariatric surgery (In-network only)
- Chiropractor care (up to 20 visits/calendar year/combined in-/out-of-network)
- 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 (**preauthorization** required)

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: the Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Global HR Service Center at 800.556.6044. 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 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: Anthem at 844.412.2976, or the Department of Labor's Employee Benefits Security Administration at 866.444.EBSA (3272), or 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 800.556.6044.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800.556.6044.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800.556.6044.

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 800.556.6044.

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 *copayment*	$25
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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 *copayment*	$25
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,560**

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

The plan's overall deductible	$500
Specialist *copayment*	$25
Hospital (facility) *coinsurance*	20%
Other *coinsurance*	20%

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	$75
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$775**

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

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Bank of America Corporation:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
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- 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, **800.556.6044**, TTY: 711, 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, 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 800.556.6044 (TTY: 711, 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 800.556.6044 (TTY: 711, 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 800.556.6044 (TTY: 711, 800.556.6044).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800.556.6044 (TTY: 711, 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 800.556.6044 (TTY: 711, 800.556.6044).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800.556.6044 (телетайп: 711, 800.556.6044).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 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 800.556.6044 (TTY: 711, 800.556.6044).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800.556.6044 (ATS : 711, 800.556.6044).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800.556.6044 (TTY: 711, 800.556.6044).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800.556.6044 (TTY: 711, 800.556.6044).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800.556.6044 (TTY: 711, 800.556.6044).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800.556.6044 (TTY: 711, 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。800.556.6044 (TTY: 711, 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.

فراهم می باشد. ب تماس بگیرید 800.556.6044 (TTY: 711, 800.556.6044) .

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 800.556.6044 (TTY: 711, 800.556.6044) पर कॉल करें।.

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

.ծառայություններ: Զանգահարեք 800.556.6044 (TTY (հեռատիպ)՝ 711, 800.556.6044):

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 800.556.6044 (TTY: 711, 800.556.6044).

Is this showing correctly?

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800.556.6044 (TTY: 711, 800.556.6044).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں800.556.6044 (TTY: 711, 800.556.6044).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 800.556.6044 (TTY: 711, 800.556.6044) ។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800.556.6044 (TTY: 711, 800.556.6044) 'ਤੇ ਕਾਲ ਕਰੋ। Is this showing correctly?

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 ।

.800.556.6044 (TTY: 711, 800.556.6044) רופט .אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800.556.6044 (መስማት ለተሳናቸው: 711, 800.556.6044. Is this showing correctly?

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800.556.6044 (TTY: 711, 800.556.6044).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800.556.6044 (TTY: 711, 800.556.6044).

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800.556.6044 (TTY: 711, 800.556.6044).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800.556.6044 (TTY: 711, 800.556.6044).

KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800.556.6044 (TTY: 711, 800.556.6044).

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800.556.6044 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 711, 800.556.6044).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800.556.6044 (телетайп: 711, 800.556.6044).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 800.556.6044(टिटिवाइ: 711, 800.556.6044)।

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 800.556.6044 (TTY: 711, 800.556.6044).

ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး
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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: 800.556.6044 (TTY: 711, 800.556.6044).

LALE: Ñe kwōj kōnono Kajin Ṃajōḷ, kwomaroñ bōk jerbal in jipañ ilo kajin ṇe aṃ ejjeḷọk wōṇāān. Kaalọk 800.556.6044 (TTY: 711, 800.556.6044).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 800.556.6044 (TTY: 711, 800.556.6044).

MEI AUCHEA: Ika iei foosun fonuomw: Foosun Chuuk, iwe en mei tongeni omw kopwe angei aninisin chiakku, ese kamo. Kori 800.556.6044 (TTY: 711, 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 800.556.6044 (TTY: 711, 800.556.6044).

ATENSYON: Kung nagsulti ka og Cebuano, aduna kay magamit nga mga serbisyo sa tabang sa lengguwahe, nga walay bayad. Tawag sa 800.556.6044 (TTY: 711, 800.556.6044).

ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 800.556.6044 (TTY: 711, 800.556.6044).

KUMBUKA: Ikiwa unazungumza Kiswahili, unaweza kupata, huduma za lugha, bila malipo. Piga simu 800.556.6044 (TTY: 711, 800.556.6044).

PERHATIAN: Jika Anda berbicara dalam Bahasa Indonesia, layanan bantuan bahasa akan tersedia secara gratis. Hubungi 800.556.6044 (TTY: 711, 800.556.6044.

DİKKAT: Eğer Türkçe konuşuyor iseniz, dil yardımı hizmetlerinden ücretsiz olarak yararlanabilirsiniz. 800.556.6044 (TTY: 711, 800.556.6044 irtibat numaralarını arayın.

ئاگاداری: ئەگەر بە زمانی کوردی قسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە 800.556.6044 800.556.6044 (TTY: 711, 800.556.6044) بکە.

శ్రద్ధ పెట్టండి: ఒకవేళ మీరు తెలుగు భాష మాట్లాడుతున్నట్లయితే, మీ కొరకు తెలుగు భాషా సహాయక సేవలు ఉచితంగా లభిస్తాయి. 800.556.6044 (TTY: 711, 800.556.6044) కు కాల్ చేయండి.

PIↃ KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atɔ̈ kuka lëu yök abac ke cïn wënh cuatë piny. Yuɔpë 800.556.6044 (TTY: 711, 800.556.6044)

MERK: Hvis du snakker norsk, er gratis språkassistansetjenester tilgjengelige for deg. Ring 800.556.6044 (TTY: 711, 800.556.6044).

ATENCIÓ: Si parleu Català, teniu disponible un servei d"ajuda lingüística sense cap càrrec. Truqueu al 800.556.6044 (TTY: 711, 800.556.6044).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 800.556.6044 (TTY: 711, 800.556.6044).

Ige nti: O buru na asu Ibo asusu, enyemaka diri gi site na call 800.556.6044 (TTY: 711, 800.556.6044).

AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 800.556.6044 (TTY: 711, 800.556.6044).

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E NĀNĀ MAI: Inā hoʻopuka ʻoe i ka ʻōlelo [hoʻokomo ʻōlelo], loaʻa ke kōkua manuahi iā ʻoe.
E kelepona iā 800.556.6044 (TTY: 711, 800.556.6044).

MAANDO: To a waawi Adamawa, e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 800.556.6044 (TTY: 711, 800.556.6044).

Hagsesda: iyuhno hyiwoniha tsalagi gawonihisdi. Call 800.556.6044 (TTY: 711, 800.556.6044)

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ANOMPA PA̲ PISAH: Chahta makilla ish anompoli hokma̲, kvna hosh Nahollo Anompa ya̲ pipilla hosh chi̲ tosholahinla. Atoko̲, hattak yvmma̲ im anompoli chi bvnnakmvt, holhtina pa̲ pa̲yah: 800.556.6044 (TTY: 711, 800.556.6044).