



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 2023

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 ?	<table border="1"> <thead> <tr> <th></th> <th>In-Network</th> <th>Out-of-Network</th> </tr> </thead> <tbody> <tr> <td>Individual:</td> <td>\$1,200</td> <td>\$2,400</td> </tr> <tr> <td>Family:</td> <td>\$2,400</td> <td>\$4,800</td> </tr> </tbody> </table>		In-Network	Out-of-Network	Individual:	\$1,200	\$2,400	Family:	\$2,400	\$4,800	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 1 st of each calendar year.
	In-Network	Out-of-Network									
Individual:	\$1,200	\$2,400									
Family:	\$2,400	\$4,800									
Are there services covered before you meet your deductible ?	Yes. Preventive care services 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 ?	<table border="1"> <thead> <tr> <th></th> <th>In-Network</th> <th>Out-of-Network</th> </tr> </thead> <tbody> <tr> <td>Individual:</td> <td>\$3,500</td> <td>\$7,000</td> </tr> <tr> <td>Family:</td> <td>\$7,000</td> <td>\$14,000</td> </tr> </tbody> </table>		In-Network	Out-of-Network	Individual:	\$3,500	\$7,000	Family:	\$7,000	\$14,000	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.
	In-Network	Out-of-Network									
Individual:	\$3,500	\$7,000									
Family:	\$7,000	\$14,000									
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 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, except for prescription drug [coinsurance](#) costs, are after your [deductible](#) has been met, if a [deductible](#) applies. The prescription drug [copayments](#) and [coinsurance](#) costs 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	\$20 copayment	40% coinsurance	—————none—————
	Specialist visit	20% coinsurance	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	—————none—————
	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	\$0 copayment for 30-day supply; \$0 copayment 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 at CVS 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	30% coinsurance , up to \$100 max for 30-day supply; \$200 max for 90-day supply; no charge for certain preventive drugs retail and mail	40% of CVS Caremark discounted rate	
	Non-preferred brand drugs	45% coinsurance , up to \$150 max for 30-day supply; \$300 max for 90-day supply; no charge for certain preventive drugs retail and mail	40% of CVS Caremark discounted rate	
	Specialty drugs , including Specialty fertility drugs	Applicable generic copayment or brand coinsurance /retail only through Caremark Specialty Pharmacy; no charge 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.
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—————

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 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	20% coinsurance	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	\$20 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: 20% coinsurance Postnatal office visits: 20% coinsurance	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		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	Home health care	20% coinsurance	40% coinsurance	Limited to 120 visits/calendar year/combined in-/out-of-network; includes private duty nursing in-network for terminal illness if pre-authorized
	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	Limited to 100 days/calendar year combined in-/out-of-network; out-of-network facility is subject to a \$500 penalty is not pre-authorized
	Skilled nursing care	20% coinsurance	40% coinsurance	_____none_____
	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:

<p>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</p>		
<ul style="list-style-type: none"> • Cosmetic surgery (unless deemed medically necessary or stated in the Summary Plan Description and subsequent updates) • Long-term care 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Private-duty nursing (unless in lieu of inpatient hospice after preauthorization) 	<ul style="list-style-type: none"> • 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 \$5,000 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 BCBS 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, kwijigo 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](#) \$1,200
- [Specialist](#) *coinsurance* 20%
- 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:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$0
Coinsurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

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

- The [plan's](#) overall [deductible](#) \$1,200
- [Specialist](#) *coinsurance* 20%
- 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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$200
Coinsurance	\$900
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,320

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

- The [plan's](#) overall [deductible](#) \$1,200
- [Specialist](#) *coinsurance* 20%
- 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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,200
Copayments	\$0
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,500

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, **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: 711, 800.556.6044-1).

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).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተሎ ቁጥር ይደውሉ 800.556.6044 (መስማት ለተሳናቸው: 711, 800.556.6044).

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, ໂດຍບໍ່ເສັຍຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 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(टिडिवाइ: 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).

ဟံ့သ့ၣ်ဟံ့သး- နမ့ၢ်ကတိၢ် ကညီ ကျိၣ်အသိ, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၢ်ဘျုးလၢၢ်စ့ၢ် နီတံၢ်ဘၣ်သ့ၣ်န့ၣ်လီၤ. ကိး 800.556.6044 (TTY: 711, 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: 800.556.6044 (TTY: 711, 800.556.6044).

LALE: Ñe kwōj kōnono Kajin Majōl, kwomaroñ bōk jermal in jipañ ilo kajin ñe am ejjelok wōñāān. Kaalok 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.

ناگاداری: نهگر به زمانی کوردی قهسه دهکیت، خزمهتگوزاریهکانی یارمتهی زمان، بهخوری، بو تو بردهسته. پهپهندی به 800.556.6044 800.556.6044 (TTY: 711, 800.556.6044) بکه.

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.

PII KENE: Na ye jam në Thuɔŋjaŋ, ke kuɔny yenë kɔc waar thook atö 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 språkassistanstjenester 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).

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 800.556.6044 (TTY: 711, 800.556.6044).

Wann du Deutsch schwetzsch, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 800.556.6044 (TTY: 711, 800.556.6044).

E NĀNĀ MAI: Inā ho‘opuka ‘oe i ka ‘ōlelo [ho‘okomo ‘ōlelo], loa‘a ke kōkua manuahi iā ‘oe.
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)

ATENSIÓN: Yanggen un tungó I linguahén Chamoru, i setbision linguahé gaige para hagu dibatde ha . Agang I 800.556.6044 (TTY: 711, 800.556.6044).

