



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 <u>deductible</u>?	<table border="0"> <tr> <td></td> <td style="text-align: center;">In-Network</td> <td style="text-align: center;">Out-of-Network</td> </tr> <tr> <td>Employee-Only:</td> <td style="text-align: right;">\$2,250</td> <td style="text-align: right;">\$2,250</td> </tr> <tr> <td>Family:</td> <td style="text-align: right;">\$4,500</td> <td style="text-align: right;">\$4,500</td> </tr> </table> <p>The <u>deductible</u> doesn't apply to in-network preventive care.</p>		In-Network	Out-of-Network	Employee-Only:	\$2,250	\$2,250	Family:	\$4,500	\$4,500	<p>You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. The <u>deductible</u> 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 <u>deductible</u>.</p>
	In-Network	Out-of-Network									
Employee-Only:	\$2,250	\$2,250									
Family:	\$4,500	\$4,500									
Are there other <u>deductibles</u> for specific services?	<p>No.</p>	<p>You don't have to meet separate <u>deductibles</u> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.</p>									
Is there an <u>out-of-pocket limit</u> on my expenses?	<p>Yes, based on whether you use in-network or out-of-network providers:</p> <p>In-Network – \$4,000 Employee-Only Coverage; \$8,000 Family Coverage for all covered members, up to \$6,850 per covered member in Family Coverage</p> <p>Out-of-Network - \$5,500 Employee-Only Coverage; \$11,000 Family Coverage</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one 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 coinsurance amounts.</p>									
What is not included in the <u>out-of-pocket limit</u>?	<p>Premiums, pre-authorization penalty amounts, balance-billed charges and health care this plan doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>									

Receipt of this document does not entitle you to benefits offered by Bank of America. If there is any discrepancy between the information in this SBC and the terms of the official plan documents, the official plan documents govern. Bank of America reserves the right to amend or terminate this plan in its sole discretion at any time and for any reason. Bank of America also retains the discretion to interpret any terms or language used in this SBC.

Questions: Call 1-844-412-2976 or visit www.Anthem.com. If you aren't clear about any of the underlined terms used in this form, see the Glossary.

You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-556-6044 to request a copy.

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 <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.anthem.com or call 1-844-412-2976 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 **coinsurance** amounts.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20%, after deductible	40%, after deductible	—————none—————
	Specialist visit	20%, after deductible	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/combined in-/out-of-network 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 <u>prescription drug coverage</u> is available at www.caremark.com or call 1-800-701-5833	Generic drugs (coinsurance per prescription)	20%, after deductible (no deductible for preventive drugs)	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 a limit to the number of refills available through your retail pharmacy. Please contact CVS Caremark for further details.
	Preferred brand drugs (coinsurance per prescription)	20%, after deductible (no deductible for preventive drugs)	40% of CVS Caremark discounted rate	
	Non-preferred brand drugs (coinsurance per prescription)	20%, after deductible (no deductible for preventive drugs)	40% of CVS Caremark discounted rate	
	Specialty drugs, including Specialty fertility drugs (coinsurance per prescription)	20%, after deductible/retail only through Caremark Specialty Pharmacy (no deductible for preventive drugs)	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—————

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
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	20%, after deductible	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	20%, after deductible	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	20%, after deductible	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: 20%, after deductible; Postnatal: 20%, after deductible	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; services may not be covered if not pre-authorized
	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	
	Skilled nursing care	20%, after deductible	40%, after deductible	Limited to 100 days/calendar year, combined in-/out-of-network
	Durable medical equipment	20%, after deductible	40%, after deductible	none
	Hospice service	20%, after deductible	40%, after deductible	none

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
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 <u>excluded services</u> .)		
<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. • Preventive hand and foot care • Private-duty nursing 	<ul style="list-style-type: none"> • 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.)		
<ul style="list-style-type: none"> • Acupuncture (only in lieu of anesthesia for a covered surgery) • Bariatric surgery (In-network only) • Chiropractor care (up to 20 visits/calendar year, combined in-/out-of-network) 	<ul style="list-style-type: none"> • 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) 	<ul style="list-style-type: none"> • Infertility treatment (prior authorization required)

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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 Anthem BCBS at 1-844-412-2976, 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, kwijigo 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.*—————

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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: \$4,320
- Patient pays: \$3,220

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	\$2,250
Copays	\$0
Coinsurance	\$820
Limits or exclusions	\$150
Total	\$3,220

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

- Amount owed to providers: \$5,400
- Plan pays: \$2,470
- Patient pays: \$2,930

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	\$2,250
Copays	\$0
Coinsurance	\$600
Limits or exclusions	\$80
Total	\$2,930

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: 1-800-556-6044-1).

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 بہ زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید.

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

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।

ՈՒՇԱԴՐՈՒԹՅՈՒՆՆԵՐ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցություն.

.ծանայություններ: Ձանգահարեք 1-800-556-6044 (TTY (հեռախոս)՝ 711, 1-800-556-6044):

सुचना: 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).

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

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចុះ 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 করুন: যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নি:খরচায় ভাষা সহায়তা পরষিবো উপলব্ধ আছে। ফোন করুন ১-৮০০-৫৫৬-৬০৪৪ (TTY: ১-৮০০-৫৫৬-৬০৪৪)।

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



ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚክተለው 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: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ 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 नि:शुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-556-6044(टिडिवाइ: 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).

ဟံ့သ့ၣ်ဟံ့သး- နမ့ၢ်ကတိၢ် ကညီ ကျိၣ်အသိ, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢၣ်ဘျုးလၢၣ်စ့ၢ် နီတမံၤဘၣ်သ့န့ၣ်လီၤ. 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 totonu, mo oe, Telefoni mai: 1-800-556-6044 (TTY: 711, 1-800-556-6044).

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

ناگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆرای، بۆ تۆ بەردەستە. پەیوەندی بە 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.

PIID KENE: Na ye jam në Thuojjan, ke kuony yenë koc waar thook atö kuka lëu yök abac ke cïn wënh cuatë piny. Yuopë 1-800-556-6044 (TTY: 711, 1-800-556-6044)

MERK: Hvis du snakker norsk, er gratis språkassistanstjenester 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 Deutsch schwetzsch, 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 ho‘opuka ‘oe i ka ‘ōlelo [ho‘okomo ‘ōlelo], loa‘a ke kōkua manuahi iā ‘oe.

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).

ကျေးဇူးပြု၍ 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 jiiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-800-556-6044 (TTY: 711, 1-800-556-6044)

Dè dɛ nià kɛ dyédɛ gbo: ɔ jũ ké m̀ Bàsòbè-wùdù-po-nyò jũ ní, nií, à wuɖu kà kò d̀ò po-poò b́èin m̀ gbo kpáa. Đá 1-800-556-6044 (TTY: 711, 1-800-556-6044)

ANOMPA PA PISAH: Chahta makilla ish anompoli hokma, kvna hosh Nahollo Anompa ya pipilla hosh chi tosholahinla. Atoko, hattak yvmm̄ im anompoli chi bvnnakmvt, holhtina pa payah: 1-800-556-6044 (TTY: 711, 1-800-556-6044).