**The Boeing Company: BCBS-Advantage+ health plan-HDHP-All Locations**

**Coverage Period:** 01/01/2019 - 12/31/2019

**Coverage for:** All Coverage Tiers | **Plan Type:** HDHP

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**Summary of Benefits and Coverage:** What this Plan Covers & What You Pay For Covered Services

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, call 1-888-802-8776, refer to group number 7SPE60 when calling or visit us at [www.bcbsil.com/boeing](http://www.bcbsil.com/boeing). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at [www.healthcare.gov/sbc-glossary](http://www.healthcare.gov/sbc-glossary) or call 866-473-2016 to request a copy.

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## Important Questions

<table>
<thead>
<tr>
<th>Answer</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong>&lt;br&gt;$1,350 Self Only or $2,700 Self + Family, family level deductible may be met by one or a combination of members. Network-Nonnetwork combined.</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong>&lt;br&gt;Yes. Deductible does not apply to copayments, preventive care or vision.</td>
<td>This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong>&lt;br&gt;No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
</tbody>
</table>

**Network:** $2,700 Self Only or $5,400 Self + Family for medical and prescription drug expenses; Nonnetwork: $4,050 Self Only or $8,100 Self + Family for medical and prescription drug expenses; Family level out-of-pocket maximum may be met by one or a combination of members, plan year deductible is included in out-of-pocket maximum.

The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.

**What is not included in the out-of-pocket limit?**

Premiums, balance-billed charges, health care this plan doesn't cover, penalties for failing to obtain preauthorization, vision

Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
Will you pay less if you use a network provider? | Yes. See [www.bcbsil.com/boeing](http://www.bcbsil.com/boeing) or call 1-888-802-8776 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 a **nonnetwork 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 a **nonnetwork 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.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network</td>
<td>Nonnetwork</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
</tbody>
</table>
| | Preventive care/screening/immunization | No charge, **deductible** does not apply | Not covered | According to prescribed guidelines. 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.

<p>| If you have a test | Diagnostic test (x-ray, blood work) | 10% after <strong>deductible</strong> | 40% after <strong>deductible</strong> | ————none——— |
| | Imaging (CT/PET scans, MRIs) | 10% after <strong>deductible</strong> | 40% after <strong>deductible</strong> | ————none——— |</p>
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</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition** | Generic drugs | Retail: 10% after deductible  
Mail Order: 10% after deductible | Not covered | Retail: 30 day supply, certain preventive drugs not subject to deductible  
Mail order: 90 day supply, certain preventive drugs not subject to deductible |
| More information about [prescription drug coverage](#) is available at [www.express-scripts.com/boeing](http://www.express-scripts.com/boeing). | Preferred brand drugs | Retail: 20% after deductible  
Mail Order: 20% after deductible | Not covered | Retail: 30 day supply, certain preventive drugs not subject to deductible, Member Pay the Difference rule applies if generic available  
Mail order: 90 day supply, certain preventive drugs not subject to deductible, Member Pay the Difference rule applies if generic available |
| | Non-preferred brand drugs | Retail: 30% after deductible  
Mail Order: 30% after deductible | Not covered | Retail: 30 day supply, certain preventive drugs not subject to deductible, Member Pay the Difference rule applies if generic available  
Mail Order: 90 day supply, certain preventive drugs not subject to deductible, Member Pay the Difference rule applies if generic available |
| Specialty drugs | Specialty drug programs apply for certain high cost items | Not covered | Preauthorization may apply or you may need to obtain specialty drugs from a pharmacy designated by the service representative, failure to follow plan procedures may result in non-payment by the plan |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 10% after deductible  
40% after deductible |  
| | Physician/surgeon fees | 10% after deductible  
40% after deductible |  
| | | |  
| | | | none |

### Notes:
- **Network** (You will pay the least)
- **Nonnetwork** (You will pay the most)
- **Preauthorization** may apply or you may need to obtain specialty drugs from a pharmacy designated by the service representative, failure to follow plan procedures may result in non-payment by the plan.
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Network (You will pay the least): 10% after deductible, non-emergent care 40% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nonnetwork (You will pay the most): 10% after deductible, non-emergent care 40% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>10% after deductible</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% after deductible</td>
<td>Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>10% after deductible</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% after deductible</td>
<td>Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the plan</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% after deductible</td>
<td></td>
</tr>
</tbody>
</table>

If you have a hospital stay:
- Facility fee (e.g., hospital room):
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible
- Physician/surgeon fee:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible

If you need mental health, behavioral health, or substance abuse services:
- Outpatient services:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible
- Inpatient services:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible

Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges.

Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the plan.

Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges.

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If you need immediate medical attention:
- Emergency room care:
  - Network: 10% after deductible, non-emergent care 40% after deductible
  - Nonnetwork: 10% after deductible, non-emergent care 40% after deductible
- Emergency medical transportation:
  - Network: 10% after deductible
  - Nonnetwork: 10% after deductible
- Urgent care:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible

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If you have a hospital stay:
- Facility fee (e.g., hospital room):
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible
- Physician/surgeon fee:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible

Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges.

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If you need mental health, behavioral health, or substance abuse services:
- Outpatient services:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible
- Inpatient services:
  - Network: 10% after deductible
  - Nonnetwork: 40% after deductible

Failure to obtain preapproval for certain intensive level outpatient services may result in non-payment by the plan.

Preadmission review or preapproval required or penalty is 50% of first $2,000 of eligible charges.
<table>
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<tr>
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<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network (You will pay the least)</td>
<td>Nonnetwork (You will pay the most)</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network (You will pay the least)</td>
<td>Nonnetwork (You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% after <strong>deductible</strong></td>
<td>40% after <strong>deductible</strong></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Coverage offered through separate vision benefit</td>
<td>Coverage offered through separate vision benefit</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Coverage offered through separate vision benefit</td>
<td>Coverage offered through separate vision benefit</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Coverage offered through separate dental benefit</td>
<td>Coverage offered through separate dental benefit</td>
</tr>
</tbody>
</table>
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.)

- Children’s dental check-up
- Children’s eye exam
- Children’s glasses
- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Habilitation services
- Infertility treatment (limited coverage may apply)
- Long-term care
- Private-duty nursing (limited coverage may apply)
- Routine eye care (Adult)
- Routine foot care (limited coverage may apply)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery (limited coverage may apply)
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.; www.bcbsil.com/boeing/resources/international_travel.html

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: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 1-888-802-8776. You can also contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

Does this Coverage Meet the Minimum Value Standard? 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:

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td>$1350</td>
<td>$1350</td>
</tr>
<tr>
<td><strong>Specialist coinsurance</strong></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
<td><strong>This EXAMPLE event includes services like:</strong></td>
</tr>
<tr>
<td>Specialist office visits <em>(prenatal care)</em></td>
<td>Primary care physician office visits <em>(including disease education)</em></td>
<td>Emergency room care <em>(including medical supplies)</em></td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests <em>(blood work)</em></td>
<td>Diagnostic test <em>(x-ray)</em></td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services</td>
<td>Prescription drugs</td>
<td>Durable medical equipment <em>(crutches)</em></td>
</tr>
<tr>
<td>Diagnostic tests <em>(ultrasounds and blood work)</em></td>
<td>Durable medical equipment <em>(glucose meter)</em></td>
<td>Rehabilitation services <em>(physical therapy)</em></td>
</tr>
<tr>
<td>Specialist visit <em>(anesthesia)</em></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Example Cost</strong></td>
<td>$12,800</td>
<td>$7,400</td>
</tr>
<tr>
<td><strong>In this example, Peg would pay:</strong></td>
<td><strong>In this example, Joe would pay:</strong></td>
<td><strong>In this example, Mia would pay:</strong></td>
</tr>
<tr>
<td>Deductibles</td>
<td>$1,350</td>
<td>$1,350</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,100</td>
<td>$900</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
<td><strong>What isn’t covered</strong></td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$60</td>
<td>$60</td>
</tr>
<tr>
<td>The total Peg would pay is</td>
<td>$2,510</td>
<td>$2,310</td>
</tr>
<tr>
<td>The total Mia would pay is</td>
<td></td>
<td>$1,410</td>
</tr>
</tbody>
</table>

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

Grievance Procedure under Section 1557 of the Affordable Care Act

It is the policy of The Boeing Company ("Boeing"), as the sponsor of the Boeing health care plans ("Plans"), not to discriminate on the basis of race, color, national origin, sex, age or disability in its administration of the Plans. Boeing has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. § 18116) and its implementing regulations at 45 C.F.R. pt. 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined by contacting the Director, Benefits Compliance and Governance, The Boeing Company, 100 N. Riverside, MC 5002-8421, Chicago, IL 60606-1596, telephone 1-312-544-2297.

The Director – EEO Compliance, Global Diversity and Inclusion, The Boeing Company, 100 N. Riverside MC 5002-9140, Chicago, IL 60606-1596, telephone 800-617-1442, has been designated as the Section 1557 Coordinator to coordinate the efforts of Boeing and the Plans to ensure compliance with Section 1557 by investigating any complaints that the Plans have failed to comply with Section 1557. Any person who believes an eligible employee or eligible dependent under the Plans has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability by the Plans may file a grievance under this procedure. It is against the law for Boeing or the Plans to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the office of the Director – EEO Compliance, Global Diversity and Inclusion, The Boeing Company, 100 N. Riverside MC 5002-9140, Chicago, IL 60606-1596, telephone 800-617-1442 within sixty (60) days of the date the person filing the grievance becomes aware of the alleged discriminatory action.

- A complaint must be in writing, containing the name and address of the person filing it. Upon contacting the Director – EEO Compliance, Global Diversity and Inclusion, a Complaint Intake Form will be provided for the convenience of the person filing the grievance. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.

- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Boeing relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.

- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, generally within thirty (30) days after its filing (unless the Section 1557 Coordinator informs the complainant of a reasonable extension), including a notice to the complainant of their right to pursue further administrative or legal remedies.
The person filing the grievance may appeal the decision of the Section 1557 Coordinator by writing to the Vice-President - Global Diversity and Inclusion (“VP, GD&I”), The Boeing Company, 100 N. Riverside MC 5002-9140, Chicago, IL 60606-1596, telephone 800-617-1442 within fifteen (15) days of receiving the Section 1557 Coordinator’s decision. The VP, GD&I shall issue a written decision in response to the appeal generally within thirty (30) days after its filing (unless the VP, GD&I informs the appellant of a reasonable extension).

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services (DH&HS), Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

DH&HS complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Boeing will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements and should be contacted at 800-617-1442 for such assistance.
Resources Available in Languages Other Than English

Spanish
ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-473-2016 (las personas con discapacidad auditiva deben utilizar el servicio de retransmisión que su operadora telefónica les ofrece para realizar llamadas).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-473-2016 (有聽力障礙的人打電話時應使用他們電話服務提供商提供的中繼服務)。

Vietnamese

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-473-2016번으로 전화해 주십시오. 청각 장애가 있는 발신자는 전화번호 서비스 제공자를 통해 제공되는 중계 서비스(relay service)를 이용해야 합니다.

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-473-2016 (dapat gamitin ng mga tumatawag na may kapansanan sa pandinig ang relay service na inaalok sa pamamagitan ng service provider ng kanilang telepono).

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-473-2016 (абонентам с нарушениями слуха следует пользоваться службой коммутируемых сообщений, услуги которой предлагаются их поставщиком услуг телефонной связи).

Arabic
ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-866-473-2016 (يتبع على ضعاف السمع الذين يودون عمل مكالمات هاتفية استخدام خدمة المرحل عبر مزود خدمة الهاتف الذي يتعاملون معه).

French-Creole
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-866-473-2016 (moun ki gen pwoblèm pou tande dwe itilize sèvis relè ke konpayi telefon pa yo ofri yo lè pou yo fè yon koutfil).
ATTENTION: If you speak French, services d'aide linguistique are available. Call 1-866-473-2016 (hearing-impaired users should use the relay service offered by their telephone provider).

ATTENZIONE: Se parlate italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-866-473-2016 (gli utenti con disabilità uditive dovrebbero utilizzare il servizio di conversione offerto attraverso il proprio operatore telefonico).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-xxx-xxx-xxxx (osoby niedosłyszące zechcą skorzystać z pomocy udostępnianej przez swoją firmę telefoniczną).

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。1-866-473-2016まで、お電話にてご連絡ください。聴覚障害のお客様はご利用の電話会社によるリレーサービスをお使いください。


توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 1-866-473-2016 تماس بگیرید. کسانی که مشکلات شنوایی دارند، باید از خدمات انتقال تاماس که توسط شرکت تلفن آنات می‌شود، استفاده کنند.