

Summary of Benefits 2022

Bright Advantage Dual Access Plan (HMO D-SNP) H2288-003

New York

Kings

New York

Queens

2022 Summary of Benefits

BRIGHT ADVANTAGE DUAL ACCESS PLAN (HMO D-SNP)

H2288-003

January 1, 2022 - December 31, 2022.

Bright HealthCare is a Medicare Advantage plan with a Medicare contract. Enrollment in the Plan depends on contract renewal.

The benefit information provided does not list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please access the "Evidence of Coverage" at BrightHealthCare.com/Medicare.

This plan is a **Dual Eligible Special Needs Plan (D-SNP)** for people who are eligible for both Medicare and Medicaid. As a dual eligible beneficiary, your services are paid first by Medicare and then by Medicaid. How much Medicaid covers depends on the type of Medicaid eligibility you have. To join **Bright Advantage Dual Access Plan (HMO D-SNP)**, you must be in one of the following Medicaid eligibility categories:

- Qualified Medicare Beneficiary (QMB): Medicaid covers your Medicare Part A and B premiums, deductibles, coinsurance and copayment amounts. You are not otherwise eligible for any Medicaid benefits.
- Qualified Medicare Beneficiary Plus (QMB+): Medicaid covers your Medicare Part A and B premiums, deductibles, coinsurance and copayment amounts. You are also eligible for full Medicaid benefits, secondary to your Medicare coverage.
- Full Benefit Dual Eligible Medicaid Only: You are eligible for full Medicaid benefits. Medicaid may provide some assistance with Medicare cost-sharing. Generally, your cost share is \$0 when the service is covered by both Medicare and Medicaid. There may be instances where you have to pay Medicare cost-sharing when the service or benefit is not covered by Medicaid.

2022 Summary of Benefits

If your category of Medicaid eligibility changes, your cost-share may also increase or decrease. You must remain eligible for and enrolled in Medicaid to stay enrolled in this plan. You also must be entitled to Medicare Part A, be enrolled in Medicare Part B and live in our service area. Our service area includes the following counties in New York: Kings, New York, and Queens.

Except in emergency situations, if you use providers that are not in our network, we may not pay for these services.

For coverage and costs of Original Medicare, look in your current "Medicare & You" handbook. View it online at Medicare.gov or get a copy by calling 1-800-MEDICARE (1-800-633-4227) available 24 hours, 7 days a week including some federal holidays. TTY/TDD users should call 1-877-486-2048.

This document is available in other formats such as Braille, large print or audio.

HAVE QUESTIONS? Please call Brigh HealthCare Member Services Department at 1-844-926-4521, TTY 711 Monday – Friday 8 am - 8 pm between April 1 and September 30 and 7 days a week between October 1 to March 31, 8 am - 8 pm or visit our website at BrightHealthCare.com/Medicare.

Bright HealthCare plans are HMOs and PPOs with a Medicare contract. Bright HealthCare's New York D-SNP is an HMO with a Medicare contract and a State Medicaid Agency Contract with the New York State Department of Health. Our plans are issued through Bright HealthCare Insurance Company or one of its affiliates. Bright HealthCare Insurance Company is a Colorado Life and Health company that issues indemnity products, including EPOs offered through Medicare Advantage. An EPO is an exclusive provider organization plan that may be written on an HMO license in some states and on a Life and Health license in some states, including Colorado. Enrollment in our plans depends on contract renewal.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Monthly Plan Premium	\$0	You must keep paying your Medicare Part B premium.
		Your premium may be more if you are not receiving Extra Help.
Deductible	No deductible	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	No more than \$0 annually	Your costs may be more if your Medicaid does not cover costsharing for Medicare covered services. Includes copays and other costs for medical services for the year.
Inpatient Hospital	\$0 per stay	Your costs may be more if your Medicaid does not cover cost- sharing for Medicare covered services.
		Services may require authorization and a referral.
Outpatient Hospital	\$0 copay	Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.
		Services may require authorization and a referral.
		Please reference Evidence of Coverage (EOC) for details on specific services.
Ambulatory Surgery Center	\$0 copay	Your costs may be more if your Medicaid does not cover cost- sharing for Medicare covered services.
		Services may require authorization and a referral.
Doctor VisitsPrimary care providers	\$0 copay	Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.
• Specialists	\$0 copay	Services may require authorization and a referral.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
 Preventive Care Flu vaccine, diabetic screenings, etc. Routine Annual Physical 	\$0 copay \$0 copay	Other preventive services are available. There are some covered services that may have a cost. Services may require authorization and a referral. Services do not require authorization or a referral.
Emergency Care	\$0 copay	Your costs may be more if your Medicaid does not cover costsharing for Medicare covered services. Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours.
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	\$90 copay	Coverage is limited to \$50,000.
Urgent Care	\$0 copay	
 Diagnostic Services/Labs/Imaging Diagnostic tests and procedures Lab services MRI, CAT scan X-rays 	\$0 copay \$0 copay \$0 copay \$0 copay	Your costs may be more if your Medicaid does not cover costsharing for Medicare covered services. Services may require authorization and a referral.
Hearing Services • Routine hearing exam	\$0 copay	One routine hearing exam annually.
Hearing aid fittings and evaluationsHearing aid	\$149 per hearing aid for the advanced model	One hearing aid fitting annually. You receive 2 hearing aids every 3 years.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Dental ServicesPreventive dental (e.g., oral exam, x-rays, cleanings)	\$0 copay	Limitations may apply. See your EOC for details.
Comprehensive Dental		
 Diagnostic services 	\$0 copay	
 Restorative services 	\$0 copay	
Endodontics	\$0 copay	
 Periodontics 	\$0 copay	
• Extractions	\$0 copay	
 Implant Services, Prosthodontics, other oral/ maxillofacial surgery, other services 	\$0 - \$350 copay	Prosthodontics, other oral/ maxillofacial surgery, other service range from \$0 for surgical placement of implant body (endosteal implant) to \$350 for implant supported crowns.
 Non-routine services 	\$0 copay	
Vision Services		
Routine eye exam	\$0 copay	One exam per year.
• Retinal imaging	\$0 copay	One exam per year.
Eyeglasses (frames)	\$0 copay	\$175 allowance for frames.
• Eyeglass lenses	\$0 copay	For standard lenses (includes standard progressives).
Contact lenses	\$0 сорау	\$175 allowance in lieu of frames for
• Upgrades		contact lenses every year. \$70 allowance for polycarb lenses upgrade. \$89.50 allowance for premium progressives upgrade.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Mental Health ServicesOutpatient individual therapyOutpatient group therapy	\$0 copay \$0 copay	Services may require authorization and a referral. Your costs may be more if your Medicaid does not cover costsharing for Medicare covered services.
Skilled Nursing Facility (SNF)	\$0 per stay	Services may require authorization and a referral. Based on 2021 cost-shares. These amounts may change for 2022. Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services.
Physical Therapy	\$0 copay	Services may require authorization and a referral. Your costs may be more if your Medicaid does not cover costsharing for Medicare covered services.
Ambulance (Ground)	\$0 copay per ride	Services may require authorization. Your costs may be more if your Medicaid does not cover cost- sharing for Medicare covered services.
Transportation	\$0 copay for unlimited one way trips to approved locations	Services may require authorization.
Medicare Part B DrugsChemotherapy drugsOther Part B drugs	\$0 copay \$0 copay	Your costs may be more if your Medicaid does not cover cost-sharing for Medicare covered services. Services may require authorization.

OUTPATIENT PRESCRIPTION DRUGS		
Part D Deductible	No deductible (your deductible may be more if you are not receiving Extra Help).	
	Retail Rx 30-day supply	Mail Order 100-day supply
Initial Coverage You are in the Initial Coverage stage until you reach \$4,430 in drug costs (year to date).		
Tier 1 - Preferred Generic	\$0 copay	\$0 copay
Tiers 2 - (Generic) to 5 (Specialty Tier)	\$0 or \$1.35 for generics. \$0 or \$4 for brands. (Depending on your level of Extra Help that you receive).	\$0 or \$1.35 for generics. \$0 or \$4 for brands. (Depending on your level of Extra Help that you receive).
Tier 6 - Select Care	\$0 copay	\$0 copay
You stay in this stage until your year-to-date "out-of-pocket costs" (your payments) reach a total of \$7,050		
Tier 1 - Preferred Generic Tiers 2 - (Generic) to 5 (Specialty Tier)	\$0 copay \$0 or \$1.35 for generics. \$0 or \$4 for brands. (Depending on your level of Extra Help that you receive).	
Tier 6 - Select Care	\$0 copay	
Catastrophic Coverage	drugs for the rest of the calc 31, 2022). Depending on your level or receive, \$0 copay for all c or 5% (whichever costs m	overed drugs or \$3.95 copay ore) for generic drugs or a ug and \$9.85 copay or 5%
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Cost-Sharing may change depending on the pharmacy you choose and when you enter a new phase of the Part D benefit.

WELLNESS BENEFITS	YOU PAY / RECEIVE	WHAT YOU SHOULD KNOW
Over-The-Counter (OTC) Items	Up to \$1,980 each year	\$165 credit every month.
Healthy Foods Allowance	Up to \$360 each year for healthy foods	Receive a \$30 monthly allowance to buy healthy whole foods at approved grocery stores.
Meals and Nutritional Counseling	Receive 14 meals each month, for 12 months in the calendar year (168 total meals)	Meal programs include: Diabetes, congestive heart failure (CHF), cardiovascular disorders, dementia, chronic and disabling mental health conditions, kidney disease, and hypertension. Also includes a nutritional consultation with a registered dietician to develop a healthy eating plan.
AcupunctureMedicare-covered acupuncture	\$0 copay	Services may require authorization and a referral.
Routine acupuncture	\$0 copay	For up to 30 visits every year combined with Routine Chiropractic services.
Chiropractic ServicesMedicare-covered chiropractic care	\$0 copay	Services may require authorization and a referral.
Routine chiropractic care	\$0 сорау	For up to 30 visits every year combined with Routine Acupuncture services.
Blood Pressure Cuffs	\$0 copay	Blood pressure cuff is provided to qualifying members through our care management program.
Scales	\$0 copay	A scale is provided to qualifying members through our care management program.

WELLNESS BENEFITS	YOU PAY / RECEIVE	WHAT YOU SHOULD KNOW
Gym Membership	\$0 copay	Silver&Fit gym membership is available to you at no cost with access to fitness facilities, or Silver&Fit Steps at-home kits for members who are unable to exercise in a fitness facility or prefer to work out at home.
24/7 Doctor Advice Line	\$0 copay	A Doctor is available at no cost to you 24 hours a day, 7 days a week by web, mobile app, or phone at: 1-800-997-6196. Doctors can diagnose and prescribe medications if medically necessary.
Personal Emergency Response System (PERS)	\$0 copay	Mobile PERS device with GPS and fall detection; 24/7/365 monitoring.



Summary of Medicaid covered benefits

Services available through New York State Department of Health

In addition to the Medicare services described in the Summary of Benefits, you may be eligible for the following Medicaid benefits based on the level of your Medicaid coverage. For eligibility rules and additional information about Medicaid services, please visit: https://www.health.ny.gov/health_care/medicaid/

Inpatient Hospital Care

Inpatient Mental Health Care

Skilled Nursing Facility (SNF)

Emergency Care

Urgently Needed Services

Home Health Care

Hospice

Doctor Office Visits

Preventive Care

Foot Care

Speech Therapy

Physical Therapy/Occupational Therapy

Mental Health Care

Diagnostic Tests, Lab and Radiology

Services, and X-Rays

Outpatient Hospital Services

Outpatient Substance Abuse Services

Renal Dialysis

Ambulance Services

Routine Transportation

Diabetes Supplies and Services

Durable Medical Equipment (DME)

Prosthetic Devices

Immunizations

Dental Services

Vision Services

Hearing Services

Prescription Drug Benefits

The categories above are subject to the coverage and limitation policies listed in your Medicaid contract.

Have Questions? What you pay for covered services may depend on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to, please call: 1-800-541-2831



Nondiscrimination Notice and Assistance with Communication

Bright HealthCare does not exclude, deny benefits to, or otherwise discriminate against any individual on the basis of sex, age, race, color, national origin, or disability. "Bright Health" means Bright HealthCare plans and their affiliates.

Language assistance and alternate formats:

Assistance is available at no cost to help you communicate with us. The services include, but are not limited to:

- Interpreters for languages other than English;
- Written information in alternative formats such as large print; and
- Assistance with reading Bright HealthCare websites.

To ask for help with these services, please call 1-844-926-4521.

If you think that we failed to provide language assistance or alternate formats, or you were discriminated against because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Bright HealthCare Civil Rights Coordinator P.O. Box 1868 Portland, ME 04104

Phone: 1-844-926-4521

You can also file a complaint with the U.S Dept. of Health and Human Services, the Office of Civil Rights:

- Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- **Phone:** Toll-free **1-800-368-1019**, **1-800-537-7697** (TDD)
- Mail: U.S Dept. of Health and Human Services. 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201

If you need help with your complaint, please call **1-844-926-4521**. You must send the complaint within 60 days of discovering the issue.

Language Assistance and Alternate Formats

This information is available in other formats like large print. To ask for another format, please call **1-844-926-4521**.

English	ATTENTION: If you speak a language other than English, language assistance services including interpretation and written translation, free of charge, are available to you. Call (844)-926-4521.
Spanish (US)	ATENCIÓN: Si no habla inglés, tiene a su disposición servicios gratuitos de asistencia lingüística, incluidos servicios de interpretación y traducción. Llame al (844) 926-4520.
Chinese (S)	注意:如果您使用的语言并非英语,则可获得免费的语言协助服务(包括口译和笔译)。请拨打电话 (844)-926-4521。
Arabic	انتباه: إذا كنت تتحدث لغة غير الإنجليزية، فخدمات المساعدة اللغوية، ومن بينها الترجمة الشفوية والترجمة التحريرية، متاحة من أجلك، دون تكلفة اتصل بالرقم 4521-926-(844).
Bengali	মনোযোগ: আপনি যদি ইংরেজী বয্তীত অনয্ কোনও ভাষায় কথা বলেন তবে বিনা মূলেয্ বযা্খযা্মূলক এবং লিখিত অনুবাদ সহ ভাষা সহায়তা পরিষেবাগুলি আপনার জনয্ উপলভয্। (844)-926-4521 নমব্রে কল করুন।
French	ATTENTION : Si vous parlez une autre langue que l'anglais, des services d'assistance linguistique, notamment d'interprétation et de traduction écrite, sont mis gratuitement à votre disposition. Appelez le (844)-926-4521.
German	ACHTUNG: Falls Sie eine andere Sprache als Englisch sprechen, steht Ihnen eine kostenfreie fremdsprachliche Unterstützung einschließlich Dolmetschen und schriftlicher Übersetzung zur Verfügung. Wählen Sie die (844)-926-4521.
Greek	ΠΡΟΣΟΧΗ: Αν μιλάτε κάποια γλώσσα διαφορετική από τα Αγγλικά, παρέχονται δωρεάν υπηρεσίες γλωσσικής βοήθειας συμπεριλαμβανομένης της διερμηνείας και της γραπτής μετάφρασης. Καλέστε το (844)-926-4521.
Italian	ATTENZIONE: se parla una lingua diversa dall'inglese, sono disponibili servizi di assistenza linguistica gratuiti, inclusivi di interpretariato e traduzione scritta. Chiami il numero (844)-926-4521.
Japanese	ご注意:英語以外の言語を話される場合は、通訳および書面による翻訳を含めて無料の言語支援サービスをご利用いただけます。(844)-926-4521 までお電話ください。
Korean	주의: 영어가 아닌 다른 언어를 사용할 경우 번역 및 통역과 같은 무료 언어 지원 서비스를 이용하실 수 있습니다. (844)-926-4521번으로 연락하십시오.
Polish	UWAGA: Jeśli nie mówisz po angielsku, możesz skorzystać z darmowej usługi tłumaczenia ustnego i pisemnego. Zadzwoń pod numer (844)-926-4521.

Russian ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки, включая устный и письменный перевод.

ATENÇÃO: Se falar um idioma que não o inglês, estão disponíveis serviços gratuitos de

assistência de idioma, incluindo interpretação e tradução escrita. Entre em contato no número

Позвоните по телефону (844)-926-4521.

(844)-926-4521.

Portuguese

Tagalog

PAALALA: Kung nagsasalita ka ng isang wika na bukod pa sa Ingles, magagamit mo ang mga serbisyong tulong sa wika, kabilang ang pagsasalin at nakasulat na pagsasalin nang walang bayad. Tumawag sa (844)-926-4521.

Urdu

توجہ فرمائیں: اگر آپ انگریزی کے علاوہ کوئی دوسری زبان بولتے ہیں تو زبان کی معاونتی خدمات بشمول ترجمانی اور تحریری ترجمہ آپ کے لئے بلا معاوضہ دستیاب ہیں۔ کال کریں 4521-926-(844).

Vietnamese

CHÚ Ý: Nếu bạn nói một thứ tiếng nào khác ngoài tiếng Anh, bạn sẽ được cấp các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm cả thông dịch và biên dịch. Gọi số (844)-926-4521.

Navajo

Navajo Baa naanish'agha: qdaa'ni'adishni la'saad la'igii'ako dine, saad'ahilka'ana'alwo'tse' esgizii, bidishchiid bee yeel, bilhadlee'ach'i' ni. bika'adishni (844)-926-4521.

Amharic

ማሳሰብያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናንሩ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ አስተርጻሚና የጽሁፍ ትርጉም ድጋፍ አንልግሎቶችን ማግኘት ይችላሉ፡፡ በ (844)-926-4521 ይደውሉ፡፡

Burmese

အသိပေးခြင်း - အကယ်၍ သင်သည် အင်္ဂလိပ်မှအပ တစ်ခြားဘာသာစကားဖြင့် စကားပြောသူဖြစ် လျှင် စကားပြန်နှင့် ရေးသားထားသောဘာသာပြန် အပါအဝင် ဘာသာစကားကူညီပံ့ပိုးဝန်ဆောင်မှု များကို အခမဲ့ရရှိနိုင်ပါသည်။ (844)-926-4521 သို့ဖုန်းခေါ် ဆိုပါ။

Cherokee

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Cushite-Oromo

HUBACHISA: Afaan Ingilifaan aala yoo kan dubbaatan ta'e, tajaajila gargaarsa afaan hikaa sagaleen fi bareefaman dabalate kafaalti irraa bilisaan issiinif argama. (844)-926-4521 irraatti bilbila.

French Creole

ATANSYON: Si ou pale yon lang ki pa Anglè, sèvis asistans lengwistik ki gen ladan l entèpretasyon ak tradiksyon alekri, epi li disponib pou ou. Rele (844)-926-4521.

Gujarti

ધ્યાન આપો: જો તમે અંગ્રેજી સિવાય ની અન્ય કોઈ ભાષા બોલો છો, તો તમારા માટે અર્થધટન અને લેખિત અનુવાદ સિંદતની ભાષા સહ્યય સેવાઓ નિ:શુલ્ક ઉપલબ્ધ છે. (844)-926-4521 પર કૉલ કરો.

Hindi

ध्यान दें: यदि आप अंग्रेज़ी के अलावा कोई अन्य भाषा बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएं, दुभाषिया और लिखित अनुवाद सहित, उपलब्ध है। (844)-926-4521 पर कॉल करें।

Hmong

TSEEM CEEB: Yog koj hais lwm hom lus uas tsis yog Lus Askiv, yuav muaj kev pab txhais lus, suav nrog kev txhais lus hais thiab kev txhais ntaub ntawv, yam tsis tau them nqi dab tsi li. Hu rau (844)-926-4521.

Karen

ဟ်သူဉ်ဟ်သး - နမ့်္ဂကတိၤကျိဉ်လ၊အတမ့်္ဂအဲကလံးကျိဉ်ဘဉ်အဃိ, ကျိဉ်တၢ်တိစၢ၊မ၊စၢ၊တဖဉ် ပဉ်ဃုဉ် ဒီး တၢ်တဲကျိုးထံတၢ်ဒီးတၢ်ကွဲးကျိဉ်ထံကာ့တၢ်, လ၊တအိဉ်ဒီးအပူ့၊ကလံ၊, အိဉ်ဝဲဒဉ်လ၊နဂ်ီ၊ လီ၊. ဆဲးကျိုး (844)-926-4521 တက္ခုံ.

Kru / Bassa

YI LE: Ibale u mpot hop umpe handugi Ngisi, bôt ba nhola bakobol ba yé ha inyu yoñ, to u nkobol ni hop nyo tole ni mapep, nsébél nsinga unu. Sebel i nsinga ini (844)-926-4521.

Kurdish

ئاگادارى: ئەگەر بە زمانێكيتر قسە دەكەيت جگە لە ئىنگلىزى، خزمەتگوزارى زمانەوانى كە وەرگێړانى. زارەكى و وەرگێړانى ئىنگلىزى دەگرێتەوە، بەخۆړايى بەردەستە بۆ تۆ. پەيوەندى بكە بە 4521-926-(844).

Laotian

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ ລວມທັງການແປປາກເປົ່າ ແລະ ການແປເອກະສານ, ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ (844)-926-4521. Mon-Khmer សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយភាសា

ដែលរួមមានការបកប្រែផ្ទាល់មាត់ និងការបកប្រែឯកសារ ដែលឥតគិតថ្លៃ គឺមានផ្តល់ជូន

ដល់អ្នក ទូរសព្ធ (844)-926-4521។

Nepali ध्यान दिनुहोस्: यदि तपाइँ अंग्रेजी बाहेक अरु कुनै भाषा बोल्नुहुन्छ भने, तपाइँको लागि नि:शुल्क भाषा

सहायता सेवा, दोभासे र लिखित अनुवाद सहित, उपलब्ध छन्। (८४४)-१२६-४५२१ मा कल गर्नुहोस्।

Persian Farsi

، توجه: اگر به زبانی غیر از انگلیسی صحبت می کنید، خدمات تسهیلات زبانی از جمله ترجمه شفاهی و کتبی رایگان در دسترس شما قرار می گیرند. با شماره 4521-926-(844) تماس بگیرید.

Serbo-Croatian PAŽNJA: Ako govorite neki drugi jezik osim engleskoga, možete besplatno koristiti usluge

jezične podrške za tumačenje i pisano prevođenje. Nazovite (844)-926-4521.

Syriac

Thai ข้อควรทราบ: หากคุณพูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการช่วยเหลือด้านภาษาได้แก่ การล่ามและการแปลเป็นลายลักษณ์อักษรให้แก่คุณโดยไม่เสียค่าใช้จ่ายใด ๆ ติดต่อหมายเลข

โทรศัพท์ (844)-926-4521

Turkish DİKKAT: İngilizce dışında bir dil konuşuyorsanız sözlü ve yazılı çevirinin de dahil olduğu

dil yardım hizmetlerinden ücretsiz olarak faydalanabilirsiniz. (844)-926-4521 numaralı hattı

arayın.

Ukrainian УВАГА: якщо ви не розмовляєте англійською, то можете скористатися безкоштовними

послугами мовної підтримки, зокрема усного та письмового перекладу. Зателефонуйте

за телефоном (844)-926-4521.

Yiddish

ביטע אויפֿמערקן: אויב איר רעדט אַ אנדערע שפּראַך ווי ענגליש, עס עקזיסטירט פֿאַר אייך פֿרײַגעבּיקע שפּראַך אויסהעלף ביטע אויפֿמערקן: אויב איר רעדט אַ אנדערע שפּראַך ווי ענגליש, איי

.(844)-926-4521 ביטע רופט איבערזעצונג און שריפֿטלעכע איבערזעצונג. ביטע רופט 1926-4521 דינסט, אייַנשליסלעך גלייַכצייַטיקע איבערזעצונג און שריפֿטלעכע

Armenian ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե դուք չեք խոսում անգլերեն, լեզվական աջակցության ծառայությունները,

ներառյալ բանավոր և գրավոր թարգմանությունը, անվճար են ձեզ համար։ Զանգահարեք

(844)-926-4521:

Punjabi ਸਾਵਧਾਨ: ਜੇਕਰ ਤੁਸੀਂ ਅੰਗ੍ਰੇਜ਼ੀ ਤੋਂ ਇਲਾਵਾ ਕੋਈ ਹੋਰ ਭਾਸ਼ਾ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਵਿਆਖਿਆ ਅਤੇ ਲਿਖਤ

ਅਨੁਵਾਦ ਸਮੇਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਮੁਫਤ ਵਿੱਚ ਉਪਲਬਧ ਹਨ। (844)-926-4521 ਤੇ ਕਾਲ ਕਰੋ।