Bright HealthCare™

Summary of Benefits 2022

Bright Advantage Health Dollars Plan (HMO) H4709-025

Florida

Lake
Sumter

2022 Summary of Benefits

BRIGHT ADVANTAGE HEALTH DOLLARS PLAN (HMO)

H4709-025

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.

To join **Bright Advantage Health Dollars Plan (HMO)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. Our service area includes these counties in Florida: Lake and Sumter.

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 Bright 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.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Monthly Plan Premium	**$0**	You must keep paying your Medicare Part B premium.
Deductible	**No deductible**	
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**No more than $2,700 annually**	Includes copays and other costs for medical services for the year.
Inpatient Hospital	**$0 per stay**	Services may require authorization.
Outpatient Hospital	**$0 - $110 copay**	Services may require authorization. Please reference Evidence of Coverage (EOC) for details on specific services. Minimum amount for diagnostic mammograms, DEXA scans, and colonoscopies. Maximum amount for all other services.
Ambulatory Surgery Center	**$0 - $100 copay**	Services may require authorization. Minimum amount for diagnostic mammograms, DEXA scans, and colonoscopies. Maximum amount for all other services.
Doctor Visits		
• Primary care providers	**$0 copay**	
• Specialists	**$10 copay**	Services may require authorization.
Preventive Care		Other preventive services are available. There are some covered services that may have a cost.
• Flu vaccine, diabetic screenings, etc.	**$0 copay**	Services may require authorization.
• Routine Annual Physical	**$0 copay**	Services do not require authorization or a referral.
Emergency Care	**$0 - $90 copay**	Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
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		Services may require authorization.
• Diagnostic tests and procedures	**$0 - $75 copay**	Minimum copay for diagnostic colonoscopy, maximum copay for all other diagnostic procedures/ tests.
• Lab services	**$0 copay**	
• MRI, CAT scan	**$0 - $75 copay**	Maximum copay for MRI, CT, and PET scans. $35 copay for Ultrasound and other general imaging. Minimum copay for diagnostic DEXA scans and diagnostic mammograms.
• X-rays	**$0 copay**	
Hearing Services		
• Routine hearing exam	**$0 copay**	One routine hearing exam annually.
• Hearing aid fittings and evaluations	**$0 copay**	One hearing aid fitting annually.
• Hearing aid	**$149 per hearing aid** for the advanced model	You receive 2 hearing aids every 3 years.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Dental Services		Limitations may apply. See your EOC for details.
• Preventive dental (e.g., oral exam, x-rays, cleanings)	**$0 copay**	
Comprehensive Dental		
• Diagnostic services	**$0 copay**	
• Restorative services	**$25 – $400 copay**	Restorative services range from $25 for provisional crown to $400 for porcelain crowns.
• Endodontics	**$25 – $720 copay**	Endontics range from $25 for pulp cap to $720 for retreatment of previous root canal.
• Periodontics	**$0 – $780 copay**	Periodontics range from $0 for gingival irrigation to $780 for osseous surgery.
• Extractions	**$70 – $140 copay**	Extractions range from $70 for primary tooth to $140 for erupted tooth.
• Implant Services, Prosthodontics, other oral/ maxillofacial surgery, other services	**$0 – $1,110 copay**	Prosthodontics and other services range from $0 for surgical placement of implant body (endosteal implant) to $1,110 for abutment supported retainer for porcelain/ceramic crown.
• Non-routine services	**$0 – $300 copay**	Non-routine services range from $0 for regional anesthesia to $300 for an occlusal guard.
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 copay**	$175 allowance in lieu of frames for contact lenses every year.
• Upgrades		$70 allowance for polycarb lenses upgrade. $89.50 allowance for premium progressives upgrade.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
Mental Health Services • Outpatient individual therapy • Outpatient group therapy	 **$10 copay** **$10 copay**	Services may require authorization.
Skilled Nursing Facility (SNF)	**$0 copay** per day for days 1-20 **$178 copay** per day for days 21-100	Services may require authorization.
Physical Therapy	**$10 copay**	Services may require authorization.
Ambulance (Ground)	**$0 - $200 copay per ride**	Services may require authorization. Minimum copay for transfer from out-of-network hospital to an in-network hospital, maximum copay for all other ambulance services.
Transportation	**$0 copay for 20 one way trips every year to approved locations**	Services may require authorization. Minimum copay for transfer from out-of-network hospital to an in-network hospital, maximum copay for all other ambulance services.
Medicare Part B Drugs • Chemotherapy drugs • Other Part B drugs	 **20% of the cost** **20% of the cost**	Services may require authorization.

OUTPATIENT PRESCRIPTION DRUGS		
Part D Deductible	**No deductible**	
	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**
Tier 2 – Generic	**$5 copay**	**$10 copay**
Tier 3 – Preferred Brand	**$30 copay**	**$60 copay**
Tier 4 – Non-Preferred Brand	**$95 copay**	**$190 copay**
Tier 5 – Specialty Tier	**33% of the cost**	**Not available**
Tier 6 – Select Care	**$0 copay**	**$0 copay**
Coverage Gap 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	**$0 copay**	
Tier 2 – Generic	**25% of the cost**	
Tier 3 – Preferred Brand	**25% of the cost**	
Tier 4 – Non-Preferred Brand	**25% of the cost**	
Tier 5 – Specialty Tier	**25% of the cost**	
Tier 6 – Select Care	**$0 copay**	
Catastrophic Coverage	During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2022). **$3.95 copay or 5% (whichever costs more) for generic drugs or a preferred multi-source drug and $9.85 copay or 5% (whichever costs more) for all other drugs.**	
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
Bright Health Dollars Card	**$1,000 'Health Dollars' per year**	$250 every 3 months. Health Dollars can be used towards OTC items and your dental costs.
Meals and Nutritional Counceling	**Receive 15 meals each week for 6 weeks with a $0 copay (90 total meals). Meal delivery is included 1 time per week.** **Receive up to 30 additional meals for a $5 copay per meal**	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.
Acupuncture • Medicare-covered acupuncture • Routine acupuncture	 **$0 copay** **$0 copay**	Services may require authorization. For up to 12 visits every year combined with Routine Chiropractic services.
Chiropractic Services • Medicare-covered chiropractic care • Routine chiropractic care	 **$0 copay** **$0 copay**	Services may require authorization. For up to 12 visits every year combined with Routine Acupuncture services.

WELLNESS BENEFITS	YOU PAY / RECEIVE	WHAT YOU SHOULD KNOW
Gym Membership	**$0 copay**	SilverSneakers gym membership is available to you at no cost with access to fitness facilities, or SilverSneakers 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: 1-800-835-2362. 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.

Bright HealthCare

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 বয্াখয্ামূলক এবং লিখিত অনুবাদ সহ ভাষা সহায়্তা 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.
Portuguese	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 (844)-926-4521.
Russian	ВНИМАНИЕ: если вы не говорите на английском языке, вы можете воспользоваться бесплатными услугами языковой поддержки, включая устный и письменный перевод. Позвоните по телефону (844)-926-4521.

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: ǫdaa`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

ማሳሰቢያ: ከእንግሊዝኛ ውጪ የሆነ ቋንቋ የሚናገሩ ከሆነ ከክፍያ ነጻ የሆነ የቋንቋ አስተርጓሚና የጽሁፍ ትርጉም ድጋፍ አገልግሎቶችን ማግኘት ይችላሉ። በ (844)-926-4521 ይደውሉ።

Burmese

အသိပေးခြင်း - အကယ်၍ သင်သည် အင်္ဂလိပ်မှအပ တစ်ခြားဘာသာစကားဖြင့် စကားပြောသူဖြစ်လျှင် စကားပြန်နှင့် ရေးသားထားသောဘာသာပြန် အပါအဝင် ဘာသာစကားကူညီပံ့ပိုးဝန်ဆောင်မှုများကို အခမဲ့ရရှိနိုင်ပါသည်။ (844)-926-4521 သို့ဖုန်းခေါ်ဆိုပါ။

Cherokee

ᏧᎦᏎᏍᏓᏁ: ᏐᎢ ᎦᏬᏂᎯᏍᏗ ᏂᏬᏂᏧ ᏏᏃ ᏳᏢᏏ, ᎦᏬᏂᎯᏍᏗ ᎠᏢᏍᏕᏢᏍᎩ ᎢᏗᎳᏛᏗᏗᎢ, ᎤᏑᏯᏍᏗ ᎠᏓᏗᏍᏓᏗ ᎠᏰ ᎪᏪᎳᏅᎯ ᎠᏗᏢᎳᏅᎯ, Ꮭ ᎪᎱᏍᏗ ᏧᎬᎩᎶᏗ ᏂᎨ ᎠᏎᏊᎢ, ᏂᎯ ᎡᎶᏛᏅᎢᏍᏓᏗᏜᎢ. ᏫᏑᎯᏴᏓ (844)-926-4521.

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 અર્થઘટન અને લેખિત અનુવાદ સહિતની ભાષા સહાય 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

ပာ်သူဉ်ပာ်သး - နမ့ၢ်ကတိၤကျိာ်လၢအတမ့ၢ်အဲကလံးကျိာ်ဘဉ်အဃိ, ကျိာ်တၢ်တိစၢၤမၤစၢၤတဖဉ် ပဉ်ဃုာ်ဒီး တၢ်တဲကျိးထံတၢ်ဒီးတၢ်ကွဲးကျိာ်ထံက့ၤတၢ်, လၢတအိဉ်ဒီးအပှ့ၤကလံၤ, အိဉ်ဝဲဒဉ်လၢနဂီၢ် လီၤ. ဆဲးကျိး (844)-926-4521 တက့ၢ်.

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

ئاگاداری: ئەگەر بە زمانێکیتر قسە دەکەیت جگە لە ئینگلیزی، خزمەتگوزاری زمانەوانی کە وەرگێرانی.
زارەکی و وەرگێرانی ئینگلیزی دەگرێتەوە، بەخۆرایی بەردەستە بۆ تۆ. پەیوەندی بکە بە 4521-926-(844).

Laotian

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາອື່ນທີ່ບໍ່ແມ່ນພາສາອັງກິດ, ພວກເຮົາມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງການແປປາກເປົ່າ ແລະ ກ ານແປເອກະສານ, ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ (844)-926-4521.

Mon-Khmer

សម្គាល់៖ ប្រសិនបើអ្នកនិយាយភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស សេវាកម្មជំនួយភាសា ដែលរួមមានការបកប្រែផ្ទាល់មាត់ និងការបកប្រែឯកសារ ដែលឥតគិតថ្លៃ គឺមានផ្តល់ជូនដល់អ្នក ទូរសព្ទ (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। (844)-926-4521 मा कल गर्नुहोस्।

Persian Farsi

،توجه: اگر به زبانی غیر از انگلیسی صحبت می کنید، خدمات تسهیلات زبانی ازجمله ترجمه شفاهی و کتبی رایگان دردسترس 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

[illegible] (844)-926-4521.

Thai

ข้อควรทราบ: หากคุณพูดภาษาอื่นที่ไม่ใช่ภาษาอังกฤษ เรามีบริการช่วยเหลือด้านภาษาได้แก่การล่ามและการแปลเป็นลายลักษณ์อักษรให้แก่คุณโดยไม่เสียค่าใช้จ่ายใด ๆ ติดต่อหมายเลขโทรศัพท์ (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 פֿרײַגעביקע שפּראַך אויסהעלף דינסט, אייַנשליסלעך גלייַכצייַטיקע איבערזעצונג און שריפֿטלעכע איבערזעצונג. ביטע רופט 4521-926-(844).

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।