Bright HealthCare™

Summary of Benefits 2022

Bright Advantage Embrace Care Plan (HMO C-SNP) H4853-016

Arizona

Maricopa

Pima

2022 Summary of Benefits

BRIGHT ADVANTAGE EMBRACE CARE PLAN (HMO C-SNP)

H4853-016

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 Embrace Care Plan (HMO C-SNP)** you must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area, and have at least one of the following chronic health conditions: diabetes mellitus, heart failure or cardiovascular disease (e.g., cardiac arrhythmia or coronary artery disease). Our service area includes the following counties in Arizona: Maricopa and Pima.

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 $2,800 annually**	Includes copays and other costs for medical services for the year.
Inpatient Hospital	**$175 copay** per day for days 1-6 **$0 copay** per day for days 7-90	Services may require authorization and a referral.
Outpatient Hospital	**$0 – $100 copay**	Services may require authorization and a referral. 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 and a referral. Minimum amount for diagnostic mammograms, DEXA scans, and colonoscopies. Maximum amount for all other services.
Doctor Visits • Primary care providers • Specialists	 **$0 copay** **$0 – $10 copay**	 Services may require authorization and a referral. Minimum copay for endocrinologist, maximum copay for all other specialists.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
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 and a referral.
• Routine Annual Physical	**$0 copay**	Services do not require authorization or a referral.
Emergency Care	**$0 - $120 copay**	Copayment waived if admitted to the hospital or readmitted to the ER within 72 hours.
Worldwide Emergency Care • Urgent Care • Emergency Room • Emergency Transportation	**$120 copay**	Coverage is limited to $50,000
Urgent Care	**$0 copay**	
Diagnostic Services/Labs/ Imaging		Services may require authorization and a referral.
• Diagnostic tests and procedures	**$0 copay**	
• Lab services	**$0 copay**	
• MRI, CAT scan	**$0 - $150 copay**	Maximum copay for MRI, CT, and PET scans. Minimum copay for Ultrasound, other general imaging, diagnostic DEXA scans and diagnostic mammograms.
• X-rays	**$0 copay**	

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
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	**$699 per hearing aid** for the advanced model **$999 per hearing aid** for the premium model	You receive 2 hearing aids every year.
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**	Endodontics 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.

PREMIUM & BENEFITS	YOU PAY	WHAT YOU SHOULD KNOW
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.
Mental Health Services		Services may require authorization and a referral.
• Outpatient individual therapy	**$10 copay**	
• Outpatient group therapy	**$10 copay**	
Skilled Nursing Facility (SNF)	**$0 copay** per day for days 1-20 **$185.50 copay** per day for days 21-100	Services may require authorization and a referral. Based on 2021 cost-shares. These amounts may change for 2022.
Physical Therapy	**$10 copay**	Services may require authorization and a referral.
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 unlimited one way trips to approved locations**	Services may require authorization.
Medicare Part B Drugs		Services may require authorization.
• Chemotherapy drugs	**20% of the cost**	
• Other Part B drugs	**20% of the cost**	

OUTPATIENT PRESCRIPTION DRUGS		
Part D Deductible	**No deductible**	
	Retail Rx 30-day supply	**Mail Order 100-day supply**
Part D Senior Savings Select insulins covered in the Initial Coverage and Coverage Gap stages.		
Tier 2 - Generic	**$0 copay**	**$0 copay**
Tier 3 - Preferred Brand	**$35 copay**	**$70 copay**
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	**$9 copay**	**$18 copay**
Tier 3 - Preferred Brand	**$47 copay**	**$94 copay**
Tier 4 - Non-Preferred Brand	**$90 copay**	**$180 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
Over-The-Counter (OTC) Items	**Up to $150 each year**	$75 credit every 6 months.
Acupuncture • Medicare-covered acupuncture • Routine acupuncture	 **$0 copay** **$0 copay**	Services may require authorization and a referral. For up to 30 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 and a referral. 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.
Continuous Glucose Monitor (CGM)	**$0 copay**	A continuous glucose monitor will be 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

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	ᎠᏕᎶᏍᏆ: ᏣᎢ ᏕᏬᏂᎯᏍᏗ ᏱᏬᏂᎭ ᏏᏃ ᎩᏢᏏ, ᏕᏬᏂᎯᏍᏗ ᎠᏢᏍᏚᏢᏍᏜ ᎢᏗᏓᏛᏁᏗᎢ, ᎤᏠᏯᏍᏗ ᎠᏓᏁᎸᏓᏁᏗ ᎠᏜ ᎪᎯᎳᏬᏍᎯ ᎠᏁᏢᏔᏬᏍᎯ, Ꮭ ᎠᎱᏍᏗ ᏧᎬᎩᎶᏗ ᏱᎩ ᎠᏎᏊᎢ, ᏂᎯ ᏒᏣᏛᏬᎢᏍᏓᏁᎸᎢ. ᏫᏥᎯᏴᏓᏏ (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 တၢ်တဲကျိးထံတၢ်ဒီးတၢ်ကွဲးကျိာ်ထံကွၢ်တၢ်, လၢတအိဉ်ဒီးအပ့ၢ်ကလံၤ, 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 وەرگێڕانی ئینگلیزی دەگرێتەوە، بەخۆڕایی 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 (844)-926-4521 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 אויפמערקן: אויב איר רעדט אַ אנדערע שפּראַך ווי ענגליש, עס עקזיסטירט פֿאַר אייך פֿרײַגעביקע שפּראַך אויסהעלף דינסט, אײַנשליסלעך גלײַכצײַטיקע איבערזעצונג און שריפֿטלעכע איבערזעצונג. ביטע רופט (844)-926-4521.

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।