Coverage for: Individual + Family | Plan Type: HSA

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 1-800-521-2227 or at www.bcbstx.com. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$2,700 Individual / \$5,400 Family Out-of-Network: \$5,200 Individual / \$10,400 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: \$6,600 Individual / \$13,200 Family Out-of-Network: \$19,800 Individual / \$39,600 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.

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

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Virtual visits are available, please refer to your plan policy for more details.	
If you visit a health	<u>Specialist</u> visit	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
care <u>provider's</u> office or clinic	Preventive care/screening/immunization	No Charge; deductible does not apply	50% <u>coinsurance</u> after <u>deductible</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6th birthday.	
lf	Diagnostic test (x-ray, blood work)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
If you have a test	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
	Generic drugs	30% coinsurance after deductible	Not Covered	Retail covers a 30-day supply Maintenance Medications are only	
If you need drugs to treat your illness or condition	Preferred brand drugs	30% coinsurance after deductible	Not Covered	available through CVS Retail Pharmacies or CVS Mail Order.	
More information about prescription drug coverage is	Non-preferred brand drugs	30% coinsurance after deductible	Not Covered	Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.	
available at caremark.com	Specialty drugs	30% coinsurance, \$300 min/prescription, \$500 max/prescription after deductible	Not Covered	Specialty Drugs are only available through CVS Specialty Pharmacy	
If you have	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
outpatient surgery	Physician/surgeon fees	30% coinsurance after deductible	50% <u>coinsurance</u> after <u>deductible</u>	None	

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbstx.com</u>.

Common		What You Will Pay		Limitations, Exceptions, & Other	
Medical Event	Services You May Need	<u>In-Network</u> <u>Provider</u>	Out-of-Network Provider	Important Information	
modical Event		(You will pay the least)	(You will pay the most)	important information	
If you need	Emergency room care	Facility Charges; 30% coinsurance after deductible ER Physician Charges: 30% coinsurance after deductible	Facility Charges; 30% coinsurance after deductible ER Physician Charges: 30% coinsurance after deductible	None	
immediate medical attention	Emergency medical transportation	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	Ground and air transportation covered.	
	<u>Urgent care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	You may have to pay for services that are not covered by the visit fee. For an example, see "If you have a test" on page 2.	
If you have a	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .	
hospital stay	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None	
If you need mental health, behavioral health, or substance	Outpatient services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details.	
abuse services	Inpatient services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	<u>Preauthorization</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .	
	Office visits	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Cost sharing does not apply for preventive services. Depending on the type of	
If you are pregnant	Childbirth/delivery professional services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Preauthorization is required; \$250 penalty if not preauthorized Out-of-Network.	

^{*} For more information about limitations and exceptions, see the $\underline{\mathsf{plan}}$ or policy document at $\underline{\mathsf{www.bcbstx.com}}$.

Common		What You Will Pay		Limitations, Exceptions, & Other
Medical Event	Services You May Need	In-Network Provider (You will pay the least)	In-Network Provider Out-of-Network Provider	Important Information
	Home health care	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 90 visits per calendar year. <u>Preauthorization</u> is required.
	Rehabilitation services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 60 visits combined for all therapies per calendar year. Includes
If you need help recovering or have	Habilitation services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	occupational, physical, and speech therapy.
other special health needs	Skilled nursing care	30% coinsurance after deductible	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 90 days per calendar year. <u>Preauthorization</u> is required.
	Durable medical equipment	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Hospica sarvicas	50% <u>coinsurance</u> after <u>deductible</u>	Preauthorization is required.	
If your child needs	Children's eye exam	30% coinsurance after deductible	50% <u>coinsurance</u> after <u>deductible</u>	None
dental or eye care	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)

- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

Private-duty nursing

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

- Bariatric surgery
- Chiropractic care (35 visits per year)
- Hearing aids (limited to 1 per ear per 36-month period and \$1,500 max ever 36 months)

^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbstx.com</u>.

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: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. 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.

Peg is Having a Baby

(9 months of <u>in-network</u> pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,700
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700

In this example, Peg would pay:

Cost Sharing	
\$2,700	
\$10	
\$3,000	
What isn't covered	
\$60	
\$5,770	

Managing Joe's type 2 Diabetes

(a year of routine <u>in-network</u> care of a well-controlled condition)

■ The plan's overall deductible	\$2,700
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
■ Other coinsurance	30%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing		
Deductibles \$2,70		
<u>Copayments</u>	\$300	
Coinsurance	\$200	
What isn't covered		
Limits or exclusions \$20		
The total Joe would pay is	\$3,220	

Mia's Simple Fracture

(<u>in-network</u> emergency room visit and follow up care)

■ The plan's overall deductible	\$2,700
■ Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
Other coinsurance	30%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

<u>Durable medical equipment</u> (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	\$2.800

In this example, Mia would pay:

Cost Sharing		
<u>Deductibles</u>	\$2,700	
<u>Copayments</u>	\$0	
Coinsurance	\$30	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,730	



Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with <u>reasonable</u> modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator Phone: 855-664-7270 (voicemail)

Attn: Office of Civil Rights Coordinator TTY/TDD: 855-661-6965 300 E. Randolph St., 35th Floor Fax: 855-661-6960

Chicago, IL 60601 Email: civilrightscoordinator@bcbsil.com

You can file a <u>grievance</u> by mail, fax or email. If you need help filing a <u>grievance</u>, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

US Dept of Health & Human Services Phone: 800-368-1019 200 Independence Avenue SW TTY/TDD: 800-537-7697

Room 509F, HHH Building Complaint Portal:

Washington, DC 20201 ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Forms:

hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
لعربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم (TTY: 711) أو تحدث إلى مقدم الخدمة.



中文 Chinese	注意。如果激说中文,我们将先费为激得供语言协助服务。我们还免要提供适当的辅助工具和服务。以元除碍格式提供信息。致电 855-710-6984(文本电话。711)或者询您的服务提供 商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barnerefreien Lormaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-8984 (LTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપી: જી તમે ગુજરાતી બીલતા છી તો મફત શાધાકીય રાશયતા રેવાઓ તમારા માટે ઉપલબ્ધ છે. ચોગ્ય ઑક્ઝિલરી રાશય બને ઍક્સોરોબલ કૉમેંટમાં માહિતી પૂરી પાડવા માટેની હેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710 6984(TTY: 711) પર કૉલ કરી અથવા તમારા પ્રદાતા સાથે વાત કરો.
इदि। Hindi	थ्यान दें: यदि आप हिंदी बोलते हैं. तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त राहायक रााथन और रोवाएँ भी निःशुल्क उपलब्ध है। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se padi Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama 1855-710-6984 (tty: 711) o paria con il tuo fornitore.
한국어 Korean	주의: 한국이 를 사용하시는 경우 무료 언어 사원 사비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 역절한 보조 기구 및 서비스도 무료로 제공됩니다. 855 710 6984(TTY: 711)반으로 전화하거나 서비스 제공업세에 문의하십시오.
Diná Navajo	SHOOH: Diné bee yánitti'qogo, saad bee aná'awo' bee áka'anida'awo'it'áá jiik'eh ná hóló. Bee abil hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anida'wo'í áko bee baa hane'í bee hadadilyaa bich'j' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjj' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'j' hanidziih.
دارسی Farsi	توجه: اگر فارس صحبت و آکنید، خدمات پشتیبانی زبانی رایگان در دسترس شما فرار دارد. همجنون آکنگها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در فانبهای فایل دسترس، بهطور رایگان موجود بیباشند. با شماره 6984-710-855 (تلهنابی: 711) تماس یگیرید با با ارائهدهنده خود مهمیت کنید.
Polski Polish	DVACA: Osoby mówiące po polsku mogą skorzystać z bezpiatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są równiez dostępne bezpiatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации и доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6084 (ТГҮ: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng limpormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
هرمو Undu	توجه دیرہ: اگر آپ اردو ہوتے ہیں، تو آپ کے نے زیان کی مفت میٹ کی خدمات دستیاب ہیں۔ قابل رساق فارمیٹس میں مطاومات غرابیم کرنے کے لیے منا بہت معاون امداد اور خدمات بھی محت دستیاب ہیں۔6984 ×210 فائد8 (711:11TY) پر 25، کرنی یا اپنے غرابیم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cũng cấp miễn phi các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cũng cấp thông tin theo các định dạng dễ tiếp cận cũng được cũng cấp miễn phi. Vui lòng gọi theo số 855-710-6984 (Người khuyết t ặ t: 711) ho ặ c trao đổi với người cũng cấp dịch vụ của ban.