



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, visit www.bcbsil.com/bb/ind/bb_ghsa47bavilo_il_2026.pdf or by calling 1-800-892-2803. 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/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Individual: Participating \$2,000 Family: Participating \$4,000	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health Care services, services with a <u>copayment</u> , and <u>prescription drugs</u> are 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 deductible. See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Individual: Participating \$8,200 Family: Participating \$16,400	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, <u>balance billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbsil.com/blueprecisionhmo or call 1-800-892-2803 for a list of Participating 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 provider for the difference between the <u>provider's charge</u> 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 referral to see a specialist?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30/visit; <u>deductible</u> does not apply	Not Covered	None
	Specialist visit	\$60/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	25% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbsil.com/rx26h/4T	Generic drugs	Retail: \$15/prescription Mail - \$45/prescription; <u>deductible</u> does not apply	Not Covered	Drugs can be on different cost sharing tiers and the amount you may pay can differ from the amount listed. Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Certain covered drugs are limited to a 30-day supply except for select FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Any differences between the cost of the generic drug and the cost of the brand name drug will apply to the <u>deductible</u> or out-of-pocket maximum. The applicable <u>cost sharing</u> (by tier) and the cost difference between the generic and brand will never exceed the overall cost of the drug. The amount you may pay per 30-day supply of a covered insulin drug, regardless of quantity or type, shall not exceed \$35, when
	Brand drugs (Preferred)	Retail: \$30/prescription Mail - \$90/prescription; <u>deductible</u> does not apply	Not Covered	
	Brand drugs (Non-Preferred)	Retail: \$60/prescription Mail - \$180/prescription; <u>deductible</u> does not apply	Not Covered	
	Specialty drugs	\$250/prescription; <u>deductible</u> does not apply	Not Covered	

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association *For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_ghsa47bavilo_il_2026.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				obtained from a Participating Pharmacy. See your benefit booklet* for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	Not Covered	Referral required. For Outpatient Infusion Therapy, see your benefit booklet* for details.
	Physician/surgeon fees	25% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$45/visit; <u>deductible</u> does not apply	Not Covered	Must be affiliated with member's chosen medical group or <u>referral</u> required.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	Physician/surgeon fees	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/office visit; <u>deductible</u> does not apply 25% <u>coinsurance</u> for other outpatient services	Not Covered	<u>Referral</u> may be required, <u>Preatuthorization</u> may also be required; see your benefit booklet* for details. Telepsychiatry benefits and Virtual Visits are available; see your benefit booklet* for details.
	Inpatient services	25% <u>coinsurance</u>	Not Covered	
If you are pregnant	Office visits	Primary Care: \$30 <u>Specialist</u> : \$60; <u>deductible</u> does not apply	Not Covered	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <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 professional services	No Charge; <u>deductible</u> does not apply	Not Covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	Not Covered	

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association *For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_ghsa47bavilo_il_2026.pdf

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Rehabilitation services</u>	\$30/visit; <u>deductible</u> does not apply	Not Covered	
	<u>Habilitation services</u>	\$30/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	<u>Durable medical equipment</u>	No Charge; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Hospice services</u>	25% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	One visit per year. See your benefit booklet* for details.
	Children's glasses	No Charge; <u>deductible</u> does not apply	Not Covered	One pair of glasses per year up to age 19. See your benefit booklet* for details.
	Children's dental check-up	Not Covered	Not Covered	None

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association *For more information about limitations and exceptions, see the plan or policy document at www.bcbsil.com/bb/ind/bb_ghsa47bavilo_il_2026.pdf

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.)

- | | | |
|---|---|--|
| <ul style="list-style-type: none">• Acupuncture• Dental care (Adult) | <ul style="list-style-type: none">• Long-term care• Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none">• Weight loss programs |
|---|---|--|

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

- | | | |
|--|---|--|
| <ul style="list-style-type: none">• Abortion care• Bariatric surgery• Chiropractic care (Chiropractic and Osteopathic manipulation limited to 25 visits per calendar year) | <ul style="list-style-type: none">• Cosmetic surgery (when <u>medically necessary</u>)• Hearing aids (1 per ear every 24 months)• Infertility treatment (covered for 4 procedures per benefit period) | <ul style="list-style-type: none">• Private-duty nursing (with the exception of inpatient private-duty nursing)• Routine eye care (Adult, 1 visit per benefit period)• Routine foot care (when <u>medically necessary</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: the plan at 1-800-892-2803. You may also contact your state insurance department at 1-877-527-9431. 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 <https://getcovered.illinois.gov/> or call 1-866-311-1119, TTY 711.

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 on how 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: Blue Cross and Blue Shield of Illinois at 1-800-892-2803 or visit www.bcbsil.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Illinois Department of Insurance at 1-877-527-9431 or visit <http://insurance.illinois.gov>.

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? Not Applicable.

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 1-800-892-2803.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-2803.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-2803.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-892-2803.

To see examples of how this plan 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 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.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) coinsurance</u>	25%
■ <u>Other coinsurance</u>	25%

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	
Deductibles	\$2,000
Copayments	\$40
Coinsurance	\$1,600

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$3,700

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) coinsurance</u>	25%
■ <u>Other coinsurance</u>	25%

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	\$100
Copayments	\$900
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$20
The total Joe would pay is	\$1,020

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$60
■ <u>Hospital (facility) coinsurance</u>	25%
■ <u>Other coinsurance</u>	25%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)

Diagnostic test (*x-ray*)

Durable medical equipment (*crutches*)

Rehabilitation services (*physical therapy*)

Total Example Cost	\$2,800
--------------------	---------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,800
Copayments	\$300
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$2,100

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

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 reasonable 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 Attn: Office of Civil Rights Coordinator 300 E. Randolph St., 35th Floor Chicago, IL 60601	Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960 Email: civilrightscoordinator@bcbsil.com
--	--

You can file a grievance by mail, fax or email. If you need help filing a grievance, 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 200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201	Phone: 800-368-1019 TTY/TDD: 800-537-7697 Complaint Portal: 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 bcbsil.com/legal-and-privacy/non-discrimination-notice

bcbsil.com

IL1557_ENG_20250410

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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.
العربية Arabic	نٰذٰرٰي: إِذَا كُنْت تَحْدِثُ الْلُّغَةَ الْعَرَبِيَّةَ، فَسْتَوْفِرُ لَكَ خَدْمَاتَ الْمَسَاعِدِ الْلُّغَوِيَّةِ الْمَجَالِيَّةِ، كَمَا تَتَوَفَّرُ وَسَالِيَّ مَسَاعِدٍ وَخَدْمَاتٍ مُنَاسِبَةٍ لِتُوْفِيرِ الْمَعْلُومَاتِ بِتَسْقِيْفَاتٍ يُمْكِنُ الْوَصُولُ إِلَيْهَا مَجَالًا. اَتَصْلِ عَلَى الرَّقْمِ (711) أَوْ تَحْدِثُ إِلَى مَقْمَنِ الْخَدْمَةِ (855-710-6984).
中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
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 Sprachassistenten-Dienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિશિલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिन्दी Hindi	ध्यान दें, यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáñílti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadílyaa bich'í' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohiji' 855-710-6984 (TTY: 711) hodíílnih doodago nika'análwo'í bich'í' hanidzih.
فارسی ¹ Farsi	توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمکها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (TTY: 711) تماس بگیرید یا با ازایده‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoni 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 в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو ² Urdu	توجه دہیں: اگر اردو بولی ہیں، تو آپ کے لئے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لئے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ (711:TTY) 855-710-6984۔ پر کال کریں۔ با اپنے فراہمیں کتنہ بے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.