



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, <https://www.anthem.com/cuhealthplan>. 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/](http://www.healthcare.gov/sbc-glossary/) or call (800) 735-6072 to request a copy.

| Important Questions   | Answers   | Why This Matters:  |
|---|---|--|
| What is the overall <a href="#">deductible</a> ?                                | <b>\$1,500</b> /single or <b>\$3,000</b> /family for <a href="#">In-Network Providers</a> .<br><b>\$3,000</b> /single or <b>\$6,000</b> /family for <a href="#">Out-of-Network Providers</a> .  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the policy, the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> for <a href="#">In-Network Providers</a> .   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .  |
| Are there other <a href="#">deductibles</a> for specific services?              | No.   | You don't have to meet <a href="#">deductibles</a> for specific services.  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <b>\$3,000</b> /single or <b>\$6,000</b> /family for <a href="#">In-Network Providers</a> .<br><b>\$6,000</b> /single or <b>\$12,000</b> /family for <a href="#">Out-of-Network Providers</a> . | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.  |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Pre-Authorization Penalties, <a href="#">Premiums</a> , <a href="#">Balance-Billing</a> charges, and Health Care this <a href="#">plan</a> doesn't cover.                                       | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .  |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes, PPO. See <a href="http://www.anthem.com/cuhealthplan">www.anthem.com/cuhealthplan</a> or call (800) 735-6072 for a list of <a href="#">network providers</a> .                             | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.   | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |



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  |
|--|--|---|--|---|
|  |  | In-Network Provider (You will pay the least)  | Non-Network Provider (You will pay the most)                               |   |
| If you visit a health care <a href="#">provider's</a> office or clinic   | Primary care visit to treat an injury or illness       | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible                           | -----none-----  |
|  | <a href="#">Specialist</a> visit                       | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible                           | -----none-----  |
|  | <a href="#">Preventive care/screening/immunization</a> | \$0 /visit  | 35% <a href="#">coinsurance</a> after deductible                           | There may be other levels of cost share that are contingent on how services are provided. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.   |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible                           | -----none-----  |
|  | Imaging (CT/PET scans, MRIs)                           | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible                           | Failure to obtain pre-authorization may result in reduced or no coverage.   |
| If you need drugs to treat your illness or condition<br><br>More information about <a href="#">prescription drug coverage</a> under CVS's Standard Control Formulary with Advanced Control Specialty Formulary is available at <a href="https://info.caremark.com/acdruglist">https://info.caremark.com/acdruglist</a> | Tier 1 - Typically Generic                             | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at CVS Retail Pharmacies and up to a 90-day supply at UCH Health Retail Pharmacies or UCH Mail Order | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply | <b>Specialty RX:</b> Per fill, a maximum of up to 30 days of Specialty medication.<br><br><b>Maintenance medication:</b> Per fill, a maximum of up to 30 days of maintenance medication may be purchased at a retail pharmacy. If using mail order for up to a 90-day supply, UCH Mail Order Prescription Service must be used for maintenance medications to be covered. |
|  | Tier 2 - Typically Preferred Brand                     | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at CVS Retail Pharmacies and up to a 90-day supply at UCH Health Retail Pharmacies or UCH Mail Order | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply | <b>Diabetic Medication &amp; Supplies:</b> Members diagnosed with diabetes may be eligible to have diabetic medication & supplies (needles, syringes, lancets, test strips) obtained at in network  |
|  | Tier 3 - Typically Non-Preferred Brand                 | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at CVS Retail  | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply |   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

| Common Medical Event                  | Services You May Need                              | What You Will Pay   |  | Limitations, Exceptions, & Other Important Information   |
|---------------------------------------|--|---|--|--|
|                                       |  | In-Network Provider<br>(You will pay the least)   | Non-Network Provider<br>(You will pay the most)                            |  |
|                                       |  | Pharmacies and up to a 90-day supply at UCHealth Retail Pharmacies or UCH Mail Order  |  | pharmacies with no applicable copayment (100% covered). Please contact member services for additional information.   |
|                                       | Tier 4 - Typically <a href="#">Specialty Drugs</a> | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply at CVS Retail Pharmacies, UCHealth Retail Pharmacies or UCH Mail Order | 20% <a href="#">coinsurance</a> after deductible for up to a 30-day supply | <p>Mail Order Pharmacy Location:<br/>University of Colorado Hospital Mail Order Prescription Service<br/>Phone (720) 848-1432<br/><a href="https://www.uchealth.org/services/pharmacy/">https://www.uchealth.org/services/pharmacy/</a></p> <p>Prescription Drugs will always be dispensed as ordered by your Provider and by applicable State Pharmacy Regulations, however you may have higher out-of-pocket costs. You may request, or your Provider may order, the Brand Name Drug. However, if a Generic Drug is available, you will need to pay the cost difference between the Generic and Brand Name Drug, in addition to your tier Copayment. The cost difference between the Generic and Brand Name Drug does not contribute to the Out-of-Pocket Annual Maximum. By law, Generic and Brand Name Drugs must meet the same standards for safety, strength, and effectiveness. The Plan reserves the right, at its discretion, to remove certain higher cost Generic Drugs from this coverage.</p> |
| <b>If you have outpatient surgery</b> | Facility fee (e.g., ambulatory surgery center)     | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible                           | Failure to obtain pre-authorization may result in reduced or no coverage.  |
|                                       | Physician/surgeon fees                             | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible                           | -----none-----   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

| Common Medical Event  | Services You May Need                            | What You Will Pay   |   | Limitations, Exceptions, & Other Important Information  |
|---|--|---|---|---|
|   |  | In-Network Provider (You will pay the least)  | Non-Network Provider (You will pay the most)  |   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 15% <a href="#">coinsurance</a> after deductible  | Covered as <a href="#">In-Network</a>   | There may be other levels of cost share that are contingent on how services are provided.   |
|   | <a href="#">Emergency medical transportation</a> | 15% <a href="#">coinsurance</a> after deductible  | Covered as <a href="#">In-Network</a>   | -----none-----  |
|   | <a href="#">Urgent care</a>                      | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | -----none-----  |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | Failure to obtain pre-authorization may result in reduced or no coverage.   |
|   | Physician/surgeon fees                           | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | -----none-----  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | Office Visit<br>15% <a href="#">coinsurance</a> after deductible;<br>Other Outpatient<br>15% <a href="#">coinsurance</a> after deductible | Office Visit<br>35% <a href="#">coinsurance</a> after deductible;<br>Other Outpatient<br>35% <a href="#">coinsurance</a> after deductible | Failure to obtain pre-authorization may result in reduced or no coverage.   |
|   | Inpatient services                               | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | Failure to obtain pre-authorization may result in reduced or no coverage.   |
| If you are pregnant   | Office visits                                    | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)<br>For inpatient admission, failure to obtain pre-authorization may result in reduced or no coverage.   |
|   | Childbirth/delivery professional services        | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  |   |
|   | Childbirth/delivery facility services            | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  |   |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | 100 visits/calendar year combined for <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> .<br>Failure to obtain pre-authorization may result in reduced or no coverage.  |
|   | <a href="#">Rehabilitation services</a>          | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  | Outpatient coverage of physical, occupational and speech therapies is limited to 40 visits each per plan year combined <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> . All rehabilitation and habilitation visits count toward your rehabilitation visit limit. |
|   | <a href="#">Habilitation services</a>            | 15% <a href="#">coinsurance</a> after deductible  | 35% <a href="#">coinsurance</a> after deductible  |   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

| Common Medical Event                          | Services You May Need                     | What You Will Pay                                |  | Limitations, Exceptions, & Other Important Information   |
|---|---|--|--|--|
|   |   | In-Network Provider (You will pay the least)     | Non-Network Provider (You will pay the most)     |  |
|   | <a href="#">Skilled nursing care</a>      | 15% <a href="#">coinsurance</a> after deductible | 35% <a href="#">coinsurance</a> after deductible | Failure to obtain pre-authorization may result in reduced or no coverage. Covers up to 100 days per plan year combined <a href="#">In-Network</a> and <a href="#">Out-of-Network</a> . |
|   | <a href="#">Durable medical equipment</a> | 15% <a href="#">coinsurance</a> after deductible | Not covered                                      | Failure to obtain pre-authorization may result in reduced or no coverage. Includes 1 wig following cancer treatment.   |
|   | <a href="#">Hospice services</a>          | 15% <a href="#">coinsurance</a> after deductible | 35% <a href="#">coinsurance</a> after deductible | Failure to obtain pre-authorization may result in reduced or no coverage.  |
| <b>If your child needs dental or eye care</b> | Eye exam                                  | Not covered                                      | Not covered                                      | -----none-----   |
|   | Glasses                                   | Not covered                                      | Not covered                                      |  |
|   | 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](#).)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)</li> </ul> | <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Long-term care</li> </ul>                     | <ul style="list-style-type: none"> <li>• Dental care (adult)</li> <li>• Preauthorization - You may have to pay for all or a portion of any test, equipment, service or procedure that is not preauthorized. To find out which services require Preauthorization and to be sure that Preauthorization has been given, you may contact us.</li> </ul> |
| <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Weight loss programs</li> </ul>                                     | <ul style="list-style-type: none"> <li>• Routine foot care unless you have been diagnosed with diabetes</li> </ul> | <ul style="list-style-type: none"> <li>• Routine vision exam</li> </ul>   |

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.

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

- Acupuncture (20 visit maximum)
- Most coverage provided outside the United States [www.bcbsglobalcore.com](http://www.bcbsglobalcore.com)
- Bariatric surgery
- Hearing Aids (limits apply)
- Chiropractic care (20 visit maximum)
- Infertility treatment

**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: Department of Labor's Employee Benefits Security Administration at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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:

ATTN: Grievances and Appeals, 700 Broadway, Mail Stop CO0104-0430, Denver, CO 80273

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform)

Division of Insurance, ICARE Section, 1560 Broadway, Suite 850, Denver, Colorado 80202, (303) 894-7490

**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](#).

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*—————

\* For more information about limitations and exceptions, see [plan](#) or policy document at <https://www.anthem.com/cuhealthplan>.



## 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 15%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 15%     |
| ■ Other <a href="#">coinsurance</a>                             | 15%     |

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 | \$12,840 |
|--------------------|----------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,000</b> |

### Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">PCP coinsurance</a>                               | 15%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 15%     |
| ■ Other <a href="#">coinsurance</a>                             | 15%     |

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 | \$7,460 |
|--------------------|---------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$894          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$2,394</b> |

### Mia's Simple Fracture (in-network emergency room visit and follow up care)

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$1,500 |
| ■ <a href="#">Specialist coinsurance</a>                        | 15%     |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 15%     |
| ■ Other <a href="#">coinsurance</a>                             | 15%     |

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 | \$2,010 |
|--------------------|---------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$1,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$77           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,577</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

(TTY/TDD: 711)

**Albanian (Shqip):** Nëse keni pyetje në lidhje me këtë dokument, keni të drejtë të merrni falas ndihmë dhe informacion në gjuhën tuaj. Për të kontaktuar me një përkthyes, telefononi (800) 735-6072

**Amharic (አማርኛ):-** ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 735-6072 ይደውሉ።

**Arabic (العربية):** إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 735-6072.

**Armenian (հայերեն).** Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 735-6072:

**Bassa (Básóó Wùdù):** M̄ dyi dyi-diè-dè b̄é bédé b̄á céè-dè nià ke dyí ní, ɔ m̀ò ni dyí-b̄édèin-dè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kp̄ǎ d̄é m̄ bídí-wùdùùn b̄ó pídyi. B̄é m̄ ké wuɖu-ziiin-nyò d̀ò gbo wùdù ke, d̄á (800) 735-6072.

**Bengali (বাংলা):** যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 735-6072 -তে কল করুন।

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