

University of Kentucky: UK-PPO Plan



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://eoc.anthem.com/eocdps/aso>. 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 (855) 634-3383 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1 \$200/person or \$400/family for UK HealthCare Providers . Tier 2 \$1,000/person or \$2,000/family for In- Network Providers . Tier 3 \$1,500/person or \$3,000/family for Non- Network Providers .	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible . <u>Tier 1 providers include:</u> UK Chandler, UK Samaritan, UK Children's, Shriner's, Lexington Surgery Center, UK St. Claire, UK Kings Daughters, Pikeville Medical Center, d/b/a Center Care <u>Tier 2 providers include:</u> Anthem's Network <u>Tier 3 providers include:</u> Non-Network
Are there services covered before you meet your deductible?	Yes. Primary Care, Specialist , Preventive Care and Vision for UK HealthCare and In- Network Providers .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 \$3,000/person or \$6,000/family for UK HealthCare Providers . Tier 2 \$4,000/person or \$8,000/family for In- Network Providers . Tier 3 \$0/person or \$0/family for Non- Network Providers . This plan has a separate Out of Pocket Maximum of \$5,000/single or \$10,000/family for Prescription Drugs .	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. <u>Tier 1 providers include:</u> UK Chandler, UK Samaritan, UK Children's, Shriner's, Lexington Surgery Center, UK St. Claire, UK Kings Daughters, Pikeville Medical Center, d/b/a Center Care <u>Tier 2 providers include:</u> Anthem's Network <u>Tier 3 providers include:</u> Non-Network

What is not included in the out-of-pocket limit?	Services deemed not medically necessary by Medical Management and/or Anthem, Premiums , balance-billing charges , 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 network provider?	Yes. This plan offers a 3-tier benefit structure. If you use Tier 1 providers, you will pay least amount. Tier 2 providers, you will pay more. Tier 3 providers, you will pay the most. See network providers at www.anthem.com then use prefix USP to view Tier 1 and Tier 2 providers.	You pay the least if you use a provider in Preferred Network . You pay more if you use a provider in In- Network . You will pay the most if you use an Out-of-Network Provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an Out-of-Network Provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral .

 All [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
		Tier 1 Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Non-Network 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	\$15/visit deductible does not apply	\$30/visit deductible does not apply	50% coinsurance after deductible	Virtual visits (Telehealth) benefits available.
	Specialist visit	\$40/visit deductible does not apply	\$50/visit deductible does not apply	50% coinsurance after deductible	Virtual visits (Telehealth) benefits available.
	LiveHealth Online (LHO) For Medical and Behavioral Health	N/A	\$0 copay No Charge	N/A	To access LHO, download the Sydney Health app to your cell phone.

	Preventive care/screening/immunization	No Charge	No Charge	50% coinsurance after deductible	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)	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	Includes Maternity Ultrasound
	Imaging (CT/PET scans, MRIs)	\$75/visit then No Charge	30% coinsurance after deductible	50% coinsurance after deductible	-----none-----

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at http://www.express-scripts.com	Tier 1 - Typically Generic	10% coinsurance (90-day Rx at UK Pharmacies and Express Scripts Home Delivery)	20% coinsurance (30-day Rx retail Pharmacy)	Not covered	\$8 minimum/\$50 maximum (30-day Rx, any pharmacy) \$24 minimum/\$100 maximum (90-day Rx UK Pharmacy/Mail Order)
	Tier 2 - Typically Preferred Brand & Non-Preferred Generic Drugs	30% coinsurance (90-day Rx at UK Pharmacies and Express Scripts Home Delivery)	40% coinsurance (30-day Rx retail pharmacy)	Not covered	\$20 minimum/\$60 maximum (30-day Rx any pharmacy) \$60 minimum/\$120 maximum (90-day Rx UK Phcy/Mail Order)
	Tier 3 - Typically Non-Preferred Brand and Generic drugs	40% coinsurance (90-day Rx at UK Pharmacies and Express Scripts Home Delivery)	50% coinsurance (30-day Rx retail pharmacy)	Not covered	\$40 minimum (30-day Rx any pharmacy) \$120 minimum (90-day Rx UK Phcy/Mail Order)
	Tier 4 - Specialty Generic	20% coinsurance	20% coinsurance	Not covered	\$8 minimum/\$50 maximum (per 30-day Rx)
	Tier 4 - Specialty Brand	\$200 per 30-day Rx	\$200 per 30-day Rx	Not covered	-----none-----
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/visit then No Charge	\$500/visit then No Charge	50% coinsurance after deductible	-----none-----
	Physician/surgeon fees/RAPS	No Charge	30% coinsurance after deductible	50% coinsurance after deductible	RAPS = Radiologist, Anesthesiology, Pathologist, Second Surgeon
If you need immediate medical attention	Emergency room care	30% coinsurance after Tier 1 Deductible	30% coinsurance after Tier 2 Deductible	Covered as In-Network at Tier 1	Tier 3 will apply the Tier 1 benefit/cost share for Deductible, Coinsurance and Out of Pocket.
	Emergency medical transportation	30% coinsurance after Tier 1 Deductible	30% coinsurance after Tier 2 Deductible	Covered as In-Network at Tier 1	Tier 3 will apply the Tier 1 benefit/cost share for Deductible, Coinsurance and Out of Pocket.

	Urgent care	\$15/visit then No Charge \$40/visit then No Charge	\$50/visit deductible does not apply	50% coinsurance after deductible	Tier 1 applies to Urgent Care at UK and the Twilight Clinic.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$300/admission then No Charge	\$1,000/admission then No Charge	50% coinsurance after deductible	60 days/benefit period for Inpatient Rehabilitation and Non-Network Providers combined.
	Physician/surgeon fees	No Charge	30% coinsurance after deductible	50% coinsurance after deductible	-----none-----

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit \$15/visit deductible does not apply Other Outpatient 10% coinsurance after deductible	Office Visit \$30/visit deductible does not apply Other Outpatient 30% coinsurance after deductible	Office Visit 50% coinsurance after deductible Other Outpatient 50% coinsurance after deductible	Office Visit -----none----- Other Outpatient -----none-----
	PT/OT/ST/Nutritional Counseling with Mental Health Primary Diagnosis	Office Visit \$20/visit deductible does not apply	Office Visit \$40/visit deductible does not apply	50% coinsurance after deductible	-----none-----
	Inpatient services	\$300/admission then No Charge	\$1,000/admission then No Charge	50% coinsurance after deductible	-----none-----
	Inpatient Physician/surgeon fees	No Charge	30% coinsurance after deductible	50% coinsurance after deductible	-----none-----
If you are pregnant	Office visits	\$15/visit for the first 1 visit deductible does not apply, then No Charge	\$30/visit for the first 1 visit then second visit to post-partum 30% coinsurance after deductible	50% coinsurance after deductible	Maternity care may include tests and services described elsewhere in the SBC.

	Childbirth/delivery professional services	No Charge	30% coinsurance after deductible	50% coinsurance after deductible	Maternity Ultrasound is covered under the Diagnostic Testing benefit.
	Childbirth/delivery facility services	\$300/admission then No Charge	\$1,000/admission then No Charge	50% coinsurance after deductible	
If you need help recovering or have other special health needs	Home health care	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	100 visits/benefit period for In- Network Providers and Non- Network Providers combined. Includes Home Infusion Therapy (services do not count toward the Home Health Care visit maximum).
	Rehabilitation services	\$20/visit deductible does not apply	\$40/visit deductible does not apply	50% coinsurance after deductible	45 visit maximum per plan year combined with the following therapies:
	Habilitation services	\$20/visit deductible does not apply	\$40/visit deductible does not apply	50% coinsurance after deductible	Physical, occupational, speech, pool/exercise hydro, acupuncture, pulmonary rehab, Cardiac Rehab and chiropractic and osteopathic manipulations.
	Skilled nursing care	Not Applicable	30% coinsurance after deductible	50% coinsurance after deductible	100 days limit/person/benefit period for In- Network Providers and Non- Network Providers combined.
	Durable medical equipment	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	-----none-----
	Hospice services	10% coinsurance after deductible	30% coinsurance after deductible	50% coinsurance after deductible	-----none-----

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Preferred Network Provider (You will pay the least)	Tier 2 In-Network Provider (You will pay more)	Tier 3 Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam (non-routine)	\$15/visit deductible does not apply	\$30/visit deductible does not apply	50% coinsurance after deductible	-----none-----
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	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](#).)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Dental care (Pediatric)
- Long-term care
- Routine foot care unless you have been diagnosed with diabetes.
- Cosmetic surgery
- Dental Check-up
- Private-duty nursing
- Weight loss programs
- Dental care (Adult)
- Glasses for a child
- Routine eye care (Adult)

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

- Bariatric surgery
- WINFertility: Lifetime Maximum for all combined is \$10,000 for medical (which includes 4 programs).
- Hearing aids one/ear every 36 months under age 18.
- Inclusive Care: Access to primary and specialty care from a provider with LGBTQIA+ experience.
- Hinge Health: musculoskeletal health (back, muscle, ankle, wrist, joint, pelvic pain and more).

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 Insurance, 215 West Main Street, Frankfort, Kentucky 40601, (502) 564-3630, (800) 595-6053, TTY: (800) 648-6056, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.gov. 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 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:

ATTN: Grievances and Appeals, P.O. Box 105568, Atlanta GA 30348-5568

Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 1-877-267-2323 x61565, www.cciio.cms.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? 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.

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 the Tier-1 self-only coverage.

Peg is Having a Baby

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$300
■ Other coinsurance	10%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles (Diag Test \$200)	\$200
Copayments (IP \$300/OB 1 st visit/\$40)	\$340
Coinsurance (Diag Testing \$150)	\$150
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$750

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$200
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$300
■ Other coinsurance	10%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)

[Diagnostic tests](#) (*blood work*)

[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$2,000
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In this example, Joe would pay:

Cost Sharing	
Deductibles (Diag Test/DME \$200)	\$200
Copayments (5 PCP copays/\$200)	\$200
Coinsurance (Diag Test/DME)	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$720

Mia's Simple Fracture

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

The plan's overall deductible	\$200
■ Specialist copayment	\$40
■ Hospital (facility) copayment	\$300
■ Other coinsurance	10%

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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles (ER/Diag Test/DME)	\$200
Copayments (Rehab \$400)	\$400
Coinsurance (ER/Diag Test/DME)	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$800

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

Language Access 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 (855) 634-3383

Amharic (አማርኛ): ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በነጻ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (855) 634-3383 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 (855) 634-3383.

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՝ (855) 634-3383:

Bassa (Bàsɔ̀ Wùdù): M̃ dyi dyi-diè-djè bě bédjé bá céè-djè nià kɛ dyí ní, ɔ mò ni dyí-bédjèin-djè bɛ̀ m̃ kɛ gbo-kpá-kpá kè bɔ́ kpɔ́ djé m̃ bídjí-wùdùùn bó pídyi. Bɛ̀ m̃ kɛ wudù-zìin-nyò dò gbo wùdù kɛ, dǎ (855) 634-3383.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্য সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (855) 634-3383 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖု (855) 634-3383 သို့ ခေါ်ဆိုပါ။

Chinese (中文): 如果您對本文件有任何疑問，您有權使用您的語言免費獲得協助和資訊。如需與譯員通話，請致電(855) 634-3383。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gɛɛr yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kɔr yin ba jam wēnē ran ye thok geryic, ke yin cɔl (855) 634-3383.

Dutch (Nederlands): Bij vragen over dit document hebt u recht op hulp en informatie in uw taal zonder bijkomende kosten. Als u een tolk wilt spreken, belt u (855) 634-3383.

Farsi (فارسي): در صورتی که سؤالی پیرامون این سند دارید، این حق را دارید که اطلاعات و کمک را بدون هیچ هزینه‌ای به زبان مادری‌تان دریافت کنید. برای گفتگو با یک مترجم شفاهی، با شماره (855) 634-3383 تماس بگیرید.

Language Access Services:

French (Français): Si vous avez des questions sur ce document, vous avez la possibilité d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour parler à un interprète, appelez le (855) 634-3383.

German (Deutsch): Wenn Sie Fragen zu diesem Dokument haben, haben Sie Anspruch auf kostenfreie Hilfe und Information in Ihrer Sprache. Um mit einem Dolmetscher zu sprechen, bitte wählen Sie (855) 634-3383.

Greek (Ελληνικά): Αν έχετε τυχόν απορίες σχετικά με το παρόν έγγραφο, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας δωρεάν. Για να μιλήσετε με κάποιον διερμηνέα, τηλεφωνήστε στο (855) 634-3383.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષયા સાથે વાત કરવા માટે, કોલ કરો (855) 634-3383.

Haitian Creole (Kreyòl Ayisyen): Si ou gen nenpòt kesyon sou dokiman sa a, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou gratis. Pou pale ak yon entèprèt, rele (855) 634-3383.

Hindi (हिंदी): अगर आपके पास इस दस्तावेज़ के बारे में कोई प्रश्न हैं, तो आपको निःशुल्क अपनी भाषा में मदद और जानकारी प्राप्त करने का अधिकार है। दुभाषिये से बात करने के लिए, कॉल करें (855) 634-3383 ।

Hmong (White Hmong): Yog tias koj muaj lus nug dab tsi ntsig txog daim ntawv no, koj muaj cai tau txais kev pab thiab lus qhia hais ua koj hom lus yam tsim xam tus nqi. Txhawm rau tham nrog tus neeg txhais lus, hu xov tooj rau (855) 634-3383.

Igbo (Igbo): O bur u na i nwere ajuju o bula gbasara akwukwo a, i nwere ikike inweta enyemaka na ozi n'asusu gi na akwughị ugwo o bula. Ka gi na okowa okwu kwuo okwu, kpoo (855) 634-3383.

Ilokano (Ilokano): Nu addaan ka iti aniaman a saludsod panggep iti daytoy a dokumento, adda karbengam a makaala ti tulong ken impormasyon babaen ti lenguahem nga awan ti bayad na. Tapno makatungtong ti maysa nga tagipatarus, awagan ti (855) 634-3383.

Indonesian (Bahasa Indonesia): Jika Anda memiliki pertanyaan mengenai dokumen ini, Anda memiliki hak untuk mendapatkan bantuan dan informasi dalam bahasa Anda tanpa biaya. Untuk berbicara dengan interpreter kami, hubungi (855) 634-3383.

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