Ambetter from Buckeye Health Plan
Elite Bronze + Vision + Adult Dental: Standard Bronze On Exchange 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, visit https://ambetter.buckeyehealthplan.com/2024-brochures.html, or call 1-877-687-1189 (TTY/TDD 1-877-941-9236). 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 https://www.healthcare.gov/sbc-glossary or call 1-877-687-1189 (TTY/TDD 1-877-941-9236) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 individual / $0 family.	See the Common Medical Events chart below for your cost for services this plan covers.
Are there services covered before you meet your deductible?	Yes, except for Non-Preferred Brand (Tier 3) and Specialty drugs (Tier 4).	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?	Yes, $3,800 individual / $7,600 family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers: $9,250 individual / $18,500 family. Not applicable for out-of-network providers.	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain preauthorization for services, 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 network provider?	Yes. See https://ambetter.buckeyehealthplan.com/findadoc or call 1-877-687-1189 (TTY/TDD 1-877-941-9236) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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 **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
		Network Provider (You will pay the least)	Out-of-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	$45 Copay / visit	Not covered	Unlimited Virtual 24/7 Care Visits received from Ambetter's designated telehealth provider covered at No Charge, providers covered in full.
	Specialist visit	$115 Copay / visit	Not covered	Covered No Limit.
	Preventive care/screening/ immunization	No charge	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)	$60 Copay / visit for laboratory & professional services 50% Coinsurance for x-ray & diagnostic imaging 50% Coinsurance for laboratory & professional services and x-ray & diagnostic imaging at other places of service	Not covered	Prior authorization may be required. Covered No Limit. Other places of service may include: Hospital, Emergency Room, or Outpatient Facility. Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits.
	Imaging (CT/PET scans, MRIs)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Preferred Generic Retail: $3 Copay / prescription Generic Retail: $35 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount.
	Preferred brand drugs (Tier 2)	Retail: $195 Copay / prescription	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
More information about **prescription drug coverage** is available at **https://ambetter.buckeyehealthplan.com/2024formulary**.	Non-preferred brand drugs (Tier 3)	Retail: $250 Copay / prescription; subject to Rx drug deductible	Not covered	retail and up to 90 days through mail order. Mail orders are subject to 2.5x retail cost-sharing amount. $3,800 individual / $7,600 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs.
	Specialty drugs (Tier 4)	Retail: 50% Coinsurance; subject to Rx drug deductible	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order. $3,800 individual / $7,600 family Rx drug deductible for preferred brand, non-preferred brand, and specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If you need immediate medical attention	Emergency room care	$2500 Copay / visit ($1250 Copay / visit for facility; $1250 Copay / visit for physician fee)	$2500 Copay / visit ($1250 Copay / visit for facility; $1250 Copay / visit for physician fee)	Covered No Limit.
	Emergency medical transportation	50% Coinsurance	50% Coinsurance	Covered No Limit. Note: Prior authorization is not required for emergency transport, however, all non-emergent transport requires prior authorization. If you receive service from an out of network ground/water ambulance provider, you may be subject to balance billing.
	Urgent care	$60 Copay / visit	Not covered	Covered No Limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	$3000 Copay / day	Not covered	Prior authorization may be required. Covered No Limit.
	Physician/surgeon fees	No charge	Not covered	Prior authorization may be required. Covered No Limit.
	Outpatient services	Office Visit: $45 Copay / visit;	Not covered	Prior authorization may be required. Covered No Limit. (Primary Care Provider (PCP) and

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services		Other Outpatient Services: 50% Coinsurance		other practitioner office visits do not require prior authorization.)
	Inpatient services	$3000 Copay / day	Not covered	Prior authorization may be required. Covered No Limit.
If you are pregnant	Office visits	$45 Copay / visit	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services, such as routine pre-natal and post-natal screenings. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	Prior authorization may be required. Cost-sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	$3000 Copay / day	Not covered	
If you need help recovering or have other special health needs	Home health care	50% Coinsurance	Not covered	Prior authorization may be required. Limited to 100 visits per year.
	Rehabilitation services	Outpatient: 50% Coinsurance Inpatient: $3000 Copay / day	Not covered	Outpatient: Prior authorization may be required. Rehabilitation therapy: speech, occupational, and physical therapy limited to 20 visits each, cardiac limited to 36 visits and pulmonary limited to 20 visits per year. Services may be used for intensive day rehabilitation. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Inpatient: Prior authorization may be required. Limited to 60 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Habilitation services	Outpatient: 50% Coinsurance Inpatient: $3000 Copay / day	Not covered	Outpatient: Prior authorization may be required. Covered No Limit. Inpatient: Prior authorization may be required. Limited to 60 days per year. Note: Limits do not apply when provided for a mental health/substance use disorder diagnosis.
	Skilled nursing care	$3000 Copay / day	Not covered	Prior authorization may be required. Limited to 90 days per year.
	Durable medical equipment	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
	Hospice services	50% Coinsurance	Not covered	Prior authorization may be required. Covered No Limit.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per year.
	Children's glasses	No charge	Not covered	Limited to 1 item per year.
	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.)

- Abortion (Except in cases when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Children)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

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

- Chiropractic care (Limited to 12 visits per year)
- Dental care (Adult-visit & item limits apply per year. $1,000 annual dollar limit per year per person.)
- Infertility treatment (Limited to services for diagnostic tests to find the cause of infertility)
- Private-duty nursing (Limited to 90 visits per year)
- Routine eye care (Adult-one visit & one item per year. Dollar allowance applies to hardware.)
- Routine foot care

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: Ambetter from Buckeye Health Plan at 1-877-687-1189 (TTY/TDD 1-877-941-9236); Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. 1-800-686-1526. 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: Ohio Department of Insurance, 50 W. Town Street, Third Floor - Suite 300 Columbus, Ohio 43215, Phone No. 1-800-686-1526.

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 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 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-687-1189 (TTY/TDD 1-877-941-9236).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-687-1189 (TTY/TDD 1-877-941-9236).

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 plan's overall deductible	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

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*	$10
Copayments	$3,600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,870**

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

The plan's overall deductible	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

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*	$3,500
Copayments	$700
Coinsurance	$400
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,620**

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

The plan's overall deductible	$0
Specialist copayment	$115
Hospital (facility) copayment	$3000
Other coinsurance	50%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$10
Copayments	$1,100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,910**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row

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

English:	If you, or someone you are helping, have questions about Ambetter from Buckeye Health Plan, and are not proficient in English, you have the right to get help and information in your language at no cost and in a timely manner. If you, or someone you are helping, have an auditory and/or visual condition that impedes communication, you have the right to receive auxiliary aids and services at no cost and in a timely manner. To receive translation or auxiliary services, please contact Member Services at 1-877-687-1189 (TTY 1-877-941-9236).
Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Buckeye Health Plan y no domina el inglés, tiene derecho a obtener ayuda e información en su idioma sin costo alguno y de manera oportuna. Si usted, o alguien a quien está ayudando, tiene un impedimento auditivo o visual que le dificulta la comunicación, tiene derecho a recibir ayuda y servicios auxiliares sin costo alguno y de manera oportuna. Para recibir servicios auxiliares o de traducción, comuníquese con Servicios para Miembros al 1-877-687-1189 (TTY 1-877-941-9236).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Buckeye Health Plan 方面的問題，且不精通英語，您有權利免費並及時以您的母語獲幫助和訊息。如果您，或您正在協助的對象有聽力和/或視力上的問題，阻礙了溝通，您有權利免費並及時獲得輔助支援與服務。若要取得翻譯或輔助服務，請聯絡會員服務部，電話是 1-877-687-1189 (TTY 1-877-941-9236)。
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Buckeye Health Plan hat und nicht Englisch spricht, haben Sie das Recht, kostenlos und zeitnah Hilfe und Informationen in Ihrer Sprache zu erhalten. Falls Sie oder jemand, dem Sie helfen, eine Hör und/oder Sehbeeinträchtigung hat, die die Kommunikation beeinflusst, haben Sie das Recht, kostenlos und zeitnah zusätzliche Hilfe und Dienstleistungen zu erhalten. Um eine Übersetzung oder zusätzliche Dienstleistungen zu erhalten, wenden Sie sich an den Kundendienst unter 1-877-687-1189 (TTY 1-877-941-9236).
Arabic:	إذا كان لديك أو لدى شخص تساعده أسئلة حول Ambetter from Buckeye Health Plan، ولم تكن بارعا باللغة الإنكليزية، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أي تكلفة وفي الوقت المناسب. إذا كنت أنت أو أي شخص تساعده تعاني من حالة سمعية و/أو بصرية تعيق التواصل، فلديك الحق في تلقي مساعدات وخدمات إضافية من دون أي تكلفة وفي الوقت المناسب. لتلقي خدمات الترجمة أو خدمات إضافية، يرجى الاتصال بـ خدمات الأعضاء ع على (TTY 1-877-941-9236) 1-877-687-1189.
Pennsylvania Dutch:	Wann du, odder epper wer dir helft, hen Frooge iwwer Ambetter from Buckeye Health Plan, un sin net proficient in Englisch, du hoscht die Recht um Helf zu griege un Information in dei Schprooch mitaus Koscht un in en zeitlich Manner. Wann du, odder epper wer dir helft, hen en Auditory un/odder Sehlich Condition die iss schlecht fer Communication, du hoscht die Recht Auxiliary Aids zu griege un Services mitaus Koscht un in en zeitlich Manner. Fer Iwwersetzing odder Auxiliary Services zu griege, sei so gut un ruff Member Services um 1-877-687-1189 (TTY 1-877-941-9236).
Russian:	Если у вас или у лица, которому вы помогаете, возникли какие либо вопросы о программе страхования Ambetter from Buckeye Health Plan, при этом вы недостаточно хорошо владеете английским языком, вы имеете право на бесплатную и своевременную помощь и информацию на своем родном языке. Если у вас или у лица, которому вы помогаете, наблюдается какое либо нарушение слуха и/или зрения, которое препятствует коммуникации, вы имеете право на бесплатные и своевременные вспомогательные услуги и помощь. Для получения услуг перевода или вспомогательных услуг обратитесь в отдел обслуживания участников программы страхования по номеру 1-877-687-1189 (TTY 1-877-941-9236).
French:	Si vous même ou une personne que vous aidez avez des questions à propos d'Ambetter from Buckeye Health Plan et que vous ne maîtrisez pas l'anglais, vous pouvez bénéficier gratuitement et en temps utile d'aide et d'informations dans votre langue. Si vous même ou une personne que vous aidez souffrez d'un trouble auditif ou visuel qui entrave la communication, vous pouvez bénéficier gratuitement et en temps utile d'aides et de services auxiliaires. Pour profiter de services de traduction ou de services auxiliaires, veuillez contacter Services aux membres au 1-877-687-1189 (TTY 1-877-941-9236).
Vietnamese:	Nếu quý vị hoặc người mà quý vị đang giúp đỡ có câu hỏi về Ambetter from Buckeye Health Plan và không thành thạo tiếng Anh, quý vị có quyền được trợ giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí và kịp thời. Nếu quý vị hoặc người mà quý vị đang giúp đỡ mắc bệnh về thính giác và/hoặc thị giác gây cản trở giao tiếp, quý vị có quyền được nhận các hỗ trợ và dịch vụ phụ trợ miễn phí và kịp thời. Để nhận dịch vụ thông dịch hoặc dịch vụ phụ trợ, vui lòng liên hệ bộ phận Dịch Vụ Thành Viên theo số 1-877-687-1189 (TTY 1-877-941-9236).
Cushite:	Isin, ykn namni biraa isin gargaartan, Ambetter from Buckeye Health Plan gaaffii qabdu yoo ta'ee fiAfaan Ingiliffaa hin beektanu taanan, yeroodhaan afaan barbaaddaniin kaffaltii tokko malee odeeffannoo barbaaddan argachuudhaaf mirga qabdu. Isin, ykn namni isin gargaartan, rakkoo dhageettii fi/ykn agartii kan haasaa keessan irratti dhiibbaa qabu qabdu taanan, gargaarsa dhageettii argachuu fi tajaajiloota kaffaltii malee argachuudhaaf mirga qabdu. Tajaajiloota hiikkaa afaanii fi dhageettii argachuudhaaf, maaloo Tajaajiloota Maamilaa karaa 1-877-687-1189 (TTY 1-877-941-9236)qunnamaa.
Korean:	귀하 또는 귀하의 도움을 받는 분이 Ambetter from Buckeye Health Plan에 대한 질문이 있는 경우 영어에 능숙하지 않으시면 해당 언어로 시의적절하게 무료 지원과 정보를 받을 권리가 있습니다. 귀하 또는 귀하의 도움을 받는 분이 청각 및/또는 시각적으로 의사소통에 장애가 있는 경우 시의적절하게 무료 보조 도구 및 서비스를 받을 권리가 있습니다. 번역 또는 보조 서비스를 받으시려면 1-877-687-1189(TTY 1-877-941-9236)번으로가입자 서비스부에 연락해주십시오.

Italian:	Se Lei o una persona a cui sta fornendo assistenza ha domande su Ambetter from Buckeye Health Plan e non ha una perfetta padronanza della lingua inglese, ha il diritto di ricevere aiuto e informazioni nella Sua lingua gratuitamente e tempestivamente. Se Lei o una persona a cui sta fornendo assistenza presenta una condizione uditiva e/o visiva che impedisce la comunicazione, ha il diritto di ricevere servizi ausiliari gratuitamente e tempestivamente. Per ricevere una traduzione o un servizio ausiliario, contatti i Servizi per i membri al numero 1-877-687-1189 (TTY 1-877-941-9236).
Japanese:	ご自身やあなたが介護している他の人が、Ambetter from Buckeye Health Planについてご質問をお持ちの場合、英語に自信がなくても無料かつタイムリーにご希望の言語でヘルプや情報を得ることができます。ご自身や、あなたが介護している他の人の聴覚や視覚の状態のためやり取りが難しい場合でも、無料かつタイムリーに補助サービスを受けることができます。翻訳や補助サービスを受けるには、1-877-687-1189 (TTY 1-877-941-9236)のメンバーサービスにご連絡ください。
Dutch:	Als u, of iemand die u helpt, vragen heeft over Ambetter from Buckeye Health Plan en de Engelse taal niet machtig is, hebt u het recht om kosteloos en tijdig hulp en informatie in uw taal te krijgen. Als u, of iemand die u helpt, een auditieve en/of visuele beperking heeft die de communicatie belemmert, hebt u recht om kosteloos en tijdig hulpmiddelen en ondersteuning te ontvangen. Om vertaal of ondersteuningsdiensten te ontvangen, kunt u contact opnemen met Ledenservice via 1-877-687-1189 (TTY 1-877-941-9236).
Ukrainian:	Якщо у вас або особи, якій ви допомагаєте, виникли запитання щодо плану Ambetter from Buckeye Health Plan, але ви чи ця особа не володієте англійською мовою, ви маєте право отримати допомогу та інформацію своєю мовою безкоштовно й своєчасно. Якщо у вас або особи, якій ви допомагаєте, є вади слуху або зору, які заважають спілкуванню, ви маєте право отримати допоміжні засоби та послуги безкоштовно й своєчасно. Щоб отримати переклад або додаткові послуги, зв'яжіться зі Службою обслуговування учасників за номером 1-877-687-1189 (TTY 1-877-941-9236).
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