

# Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2025

Capital Blue Cross<sup>1</sup>

Silver QHDHP PPO Choice 3000/10/35

Coverage For: Individual and Family | Plan Type: QHDHP PPO



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, go to <https://www.capbluecross.com/sbcsia> or call 1-800-730-7219. 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 1-800-730-7219 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$3,000/Individual, \$6,000/Family <a href="#">preferred in-network providers</a> ; \$6,000/Individual, \$12,000/Family <a href="#">non-preferred in-network providers</a> ; \$6,000/Individual, \$12,000/Family <a href="#">out-of-network providers</a> . <a href="#">Deductible</a> applies to all services, including <a href="#">prescription drug</a> , before any <a href="#">copayment</a> or <a href="#">coinsurance</a> are applied.	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 <a href="#">plan</a> , 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. in-network <a href="#">preventive services</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the annual <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 <a href="#">preventive services</a> without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> 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?	Yes. \$75 for pediatric dental. There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these <a href="#">services</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">in-network providers</a> \$7,450 Individual / \$14,900 Family; for <a href="#">out-of-network providers</a> \$10,000 Individual / \$20,000/Family. Combined <a href="#">out-of-pocket limit</a> for <a href="#">network</a> medical and <a href="#">prescription drug</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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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. For a list of <a href="#">in-network providers</a> , see <a href="http://capitalbluecross.com">capitalbluecross.com</a> or call 1-800-730-7219.	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 plan's <a href="#">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 provider's 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
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-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	\$35 <a href="#">copayment</a> /Visit	\$60 <a href="#">copayment</a> /Visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$65 <a href="#">copayment</a> /Visit	\$85 <a href="#">copayment</a> /Visit	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	No Charge	50% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply to services at <a href="#">in-network providers</a> . You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services you need 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)	10% <a href="#">coinsurance</a> for Facility Owned labs, 10% <a href="#">coinsurance</a> for Independent Labs and 10% <a href="#">coinsurance</a> for tests. 10% <a href="#">coinsurance</a> for outpatient radiology.	30% <a href="#">coinsurance</a> for Facility Owned labs, 30% <a href="#">coinsurance</a> for Independent Labs and 30% <a href="#">coinsurance</a> for tests. 30% <a href="#">coinsurance</a> for outpatient radiology.	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your plan document.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available by calling 1-800-730-7219	Generic drugs	\$10 <a href="#">copayment</a> /prescription preferred and 25% <a href="#">coinsurance</a> /prescription non-preferred (retail) \$25 <a href="#">copayment</a> /prescription preferred and 25% <a href="#">coinsurance</a> /prescription non-preferred (home delivery)			\$250 maximum copayment(retail); \$500 maximum copayment(home delivery) for non-preferred generic. Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Preferred brand drugs	\$50 <a href="#">copayment</a> /prescription (retail) \$125 <a href="#">copayment</a> /prescription (home delivery)			Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	Non Preferred brand drugs	\$100 <a href="#">copayment</a> /prescription (retail) \$250 <a href="#">copayment</a> /prescription (home delivery)			Covers up to a 30-day supply (retail) 90-day supply (home delivery).
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> /prescription preferred and 50% <a href="#">coinsurance</a> /prescription non-preferred (generic) 50% <a href="#">coinsurance</a> /prescription preferred and 50% <a href="#">coinsurance</a> /prescription non-preferred (brand)			Prescription written for up to 30 days supply. / \$800 maximum <a href="#">copayment</a> /prescription preferred and \$1,000 maximum <a href="#">copayment</a> /prescription

\*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
					non-preferred (generic) / \$800 maximum <a href="#">copayment</a> /prescription preferred and \$1,000 maximum <a href="#">copayment</a> /prescription non-preferred (brand)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> Acute Care Hospital and 10% <a href="#">coinsurance</a> Ambulatory Surgical Center	30% <a href="#">coinsurance</a> Acute Care Hospital and 30% <a href="#">coinsurance</a> Ambulatory Surgical Center	50% <a href="#">coinsurance</a>	No coverage for services at <a href="#">out-of-network</a> ambulatory surgical facilities
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your plan document.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$400 <a href="#">copayment</a> /Visit	\$400 <a href="#">copayment</a> /Visit	\$400 <a href="#">copayment</a> /Visit	<a href="#">Copayment</a> waived if admitted inpatient.
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	<a href="#">Coinsurance</a> waived for mental health and substance use disorder services.
	<a href="#">Urgent care</a>	\$100 <a href="#">copayment</a> /Visit	\$100 <a href="#">copayment</a> /Visit	\$100 <a href="#">copayment</a> /Visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient office visits: \$35 <a href="#">copayment</a> ; all other outpatient services: 10% <a href="#">coinsurance</a>	Outpatient office visits: \$35 <a href="#">copayment</a> ; all other outpatient services: 10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Inpatient services	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	\$65 <a href="#">copayment</a> /Visit	\$85 <a href="#">copayment</a> /Visit	50% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> or <a href="#">deductible</a>

\*For more information about preauthorization, see the requirements document at <https://www.capbluecross.com/preauthorization>.



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
					may apply.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	60 visits limit per benefit period. (Visit limits not applicable to mental health care and substance use disorder services.) *See <a href="#">preauthorization</a> schedule attached to your plan document.
	<a href="#">Rehabilitation services</a>	\$65 <a href="#">copayment</a> /Visit	\$85 <a href="#">copayment</a> /Visit	50% <a href="#">coinsurance</a>	Visit limits per benefit period: 30 visits combined for physical and occupational therapy; 30 visits for speech therapy. (Visit limits not applicable to mental health care and substance use disorder services.)
	<a href="#">Habilitation services</a>	\$65 <a href="#">copayment</a> /Visit	\$85 <a href="#">copayment</a> /Visit	50% <a href="#">coinsurance</a>	Visit limits per benefit period: 30 visits combined for physical and occupational therapy; 30 visits for speech therapy. (Visit limits not applicable to mental health care and substance use disorder services.)
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	120 day limit per benefit period. (Limit not applicable to mental health care and substance use disorder services.)
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Not Covered	*See <a href="#">preauthorization</a> schedule attached to your plan document.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	No Charge		Balance of retail charge after \$32 allowance	One exam and one pair of glasses once every 12 months based on last date of service.
	Children's glasses	No Charge for standard frames and lenses. See <a href="#">plan</a> document for non-standard frame benefits.		Balance of retail charge after frames and lens allowance. See <a href="#">plan</a>	One exam and one pair of glasses once every 12 months based on last date of service.



Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred In-network Provider (You will pay the least)	Non-Preferred In-network Provider (You will pay the least)	Out-of-network Provider (You will pay the most)	
				document.	
	Children's dental check-up	No Charge		20% <a href="#">coinsurance</a>	<a href="#">Deductible</a> does not apply



### Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Abortion (except in cases of rape, incest, or when the life of the mother is endangered)	• Hearing aids	• Routine foot care (unless medically necessary)
• Bariatric surgery	• Long-term care	• Weight loss programs
• Cosmetic Surgery	• Private-duty nursing	
• Dental care (Adult)	• Routine eye care (Adult)	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
• Acupuncture	• Infertility treatment	
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	

**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: 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or the Pennsylvania Insurance Department at 1-877-881-6388. 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 [pennie.com](http://pennie.com) or call 1-844-844-8040.

**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: the Pennsylvania Insurance Department at 1-877-881-6388.

### 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](#).

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$40
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$4,040</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>	\$3,000
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$700
Coinsurance	\$10
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$3,710</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>	\$3,000
■ <a href="#">Specialist copayment</a>	\$65
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

<sup>1</sup>Healthcare benefit programs issued or administered by Capital Blue Cross and/or its subsidiaries, Capital Advantage Insurance Company®, Capital Advantage Assurance Company® and Keystone Health Plan® Central. Independent licensees of the Blue Cross BlueShield Association. Communications issued by Capital Blue Cross in its capacity as administrator of programs and provider relations for all companies.



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If you believe that Capital Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in person or by mail, fax, or email at:

**Capital Blue Cross**

PO Box 779880, Harrisburg, PA 17177-9880

800.417.7842 (TTY: 711), fax: 855.990.9001

**CRC@capbluecross.com**

If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building, Washington, D.C. 20201, Toll-free 800.368.1019, 800.537.7697 (TDD). Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

### Language assistance

To talk to an interpreter in your language at no cost, call 800.962.2242 (TTY: 711).

Para hablar con un intérprete de forma gratuita, llame al 800.962.2242 (TTY: 711).

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Для бесплатного разговора с переводчиком на своем языке, позвоните по тел.: 800.962.2242 (TTY: 711).

Fa koschdefrei schwetze mit me dolmetscher in deinre Schrooch, ruf 800.962.2242 uff (TTY: 711).

무료 전화 통역 서비스 800.962.2242 (TTY: 711).

Per parlare con un interprete nella vostra lingua gratis, chiami 800.962.2242 (TTY: 711)

للتحدث مجاناً إلى مترجم للغتك، يرجى الاتصال بـ 800.962.2242 (الهاتف النصي: 711)

Pour parler à un interprète dans votre langue sans charges, téléphoner à 800.962.2242 (TTY: 711).

Um in Ihrer Sprache gebührenfrei mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800.962.2242 an (TTY: 711).

𑂄𑂔𑂕𑂖𑂗𑂘𑂙𑂚𑂛𑂜𑂝𑂞𑂟𑂠𑂡𑂢𑂣𑂤𑂥𑂦𑂧𑂨𑂩𑂪𑂫𑂬𑂭𑂮𑂯𑂰𑂱𑂲𑂳𑂴𑂵𑂶𑂷𑂸𑂺𑂹𑂻𑂼𑂽𑂾𑂿𑃀𑃁𑃂𑃃𑃄𑃅𑃆𑃇𑃈𑃉𑃊𑃋𑃌𑃍𑃎𑃏𑃐𑃑𑃒𑃓𑃔𑃕𑃖𑃗𑃘𑃙𑃚𑃛𑃜𑃝𑃞𑃟𑃠𑃡𑃢𑃣𑃤𑃥𑃦𑃧𑃨𑃩𑃪𑃫𑃬𑃭𑃮𑃯𑃰𑃱𑃲𑃳𑃴𑃵𑃶𑃷𑃸𑃹𑃺𑃻𑃼𑃽𑃾𑃿𑄀𑄁𑄂𑄃𑄄𑄅𑄆𑄇𑄈𑄉𑄊𑄋𑄌𑄍𑄎𑄏𑄐𑄑𑄒𑄓𑄔𑄕𑄖𑄗𑄘𑄙𑄚𑄛𑄜𑄝𑄞𑄟𑄠𑄡𑄢𑄣𑄤𑄥𑄦𑄧𑄨𑄩𑄪𑄫𑄬𑄭𑄮𑄯𑄰𑄱𑄲𑄳𑄴𑄵𑄶𑄷𑄸𑄹𑄺𑄻𑄼𑄽𑄾𑄿𑅀𑅁𑅂𑅃𑅄𑅅𑅆𑅇𑅈𑅉𑅊𑅋𑅌𑅍𑅎𑅏𑅐𑅑𑅒𑅓𑅔𑅕𑅖𑅗𑅘𑅙𑅚𑅛𑅜𑅝𑅞𑅟𑅠𑅡𑅢𑅣𑅤𑅥𑅦𑅧𑅨𑅩𑅪𑅫𑅬𑅭𑅮𑅯𑅰𑅱𑅲𑅳𑅴𑅵𑅶𑅷𑅸𑅹𑅺𑅻𑅼𑅽𑅾𑅿𑆀𑆁𑆂𑆃𑆄𑆅𑆆𑆇𑆈𑆉𑆊𑆋𑆌𑆍𑆎𑆏𑆐𑆑𑆒𑆓𑆔𑆕𑆖𑆗𑆘𑆙𑆚𑆛𑆜𑆝𑆞𑆟𑆠𑆡𑆢𑆣𑆤𑆥𑆦𑆧𑆨𑆩𑆪𑆫𑆬𑆭𑆮𑆯𑆰𑆱𑆲𑆳𑆴𑆵𑆶𑆷𑆸𑆹𑆺𑆻𑆼𑆽𑆾𑆿𑇀𑇁𑇂𑇃𑇄𑇅𑇆𑇇𑇈𑇉𑇊𑇋𑇌𑇍𑇎𑇏𑇐𑇑𑇒𑇓𑇔𑇕𑇖𑇗𑇘𑇙𑇚𑇛𑇜𑇝𑇞𑇟𑇠𑇡𑇢𑇣𑇤𑇥𑇦𑇧𑇨𑇩𑇪𑇫𑇬𑇭𑇮𑇯𑇰𑇱𑇲𑇳𑇴𑇵𑇶𑇷𑇸𑇹𑇺𑇻𑇼𑇽𑇾𑇿𑈀𑈁𑈂𑈃𑈄𑈅𑈆𑈇𑈈𑈉𑈊𑈋𑈌𑈍𑈎𑈏𑈐𑈑𑈒𑈓𑈔𑈕𑈖𑈗𑈘𑈙𑈚𑈛𑈜𑈝𑈞𑈟𑈠𑈡𑈢𑈣𑈤𑈥𑈦𑈧𑈨𑈩𑈪𑈫𑈬𑈭𑈮𑈯𑈰𑈱𑈲𑈳𑈴𑈶𑈵𑈷𑈸𑈹𑈺𑈻𑈼𑈽𑈾𑈿𑉀𑉁𑉂𑉃𑉄𑉅𑉆𑉇𑉈𑉉𑉊𑉋𑉌𑉍𑉎𑉏𑉐𑉑𑉒𑉓𑉔𑉕𑉖𑉗𑉘𑉙𑉚𑉛𑉜𑉝𑉞𑉟𑉠𑉡𑉢𑉣𑉤𑉥𑉦𑉧𑉨𑉩𑉪𑉫𑉬𑉭𑉮𑉯𑉰𑉱𑉲𑉳𑉴𑉵𑉶𑉷𑉸𑉹𑉺𑉻𑉼𑉽𑉾𑉿𑊀𑊁𑊂𑊃𑊄𑊅𑊆𑊇𑊈𑊉𑊊𑊋𑊌𑊍𑊎𑊏𑊐𑊑𑊒𑊓𑊔𑊕𑊖𑊗𑊘𑊙𑊚𑊛𑊜𑊝𑊞𑊟𑊠𑊡𑊢𑊣𑊤𑊥𑊦𑊧𑊨𑊩𑊪𑊫𑊬𑊭𑊮𑊯𑊰𑊱𑊲𑊳𑊴𑊵𑊶𑊷𑊸𑊹𑊺𑊻𑊼𑊽𑊾𑊿𑋀𑋁𑋂𑋃𑋄𑋅𑋆𑋇𑋈𑋉𑋊𑋋𑋌𑋍𑋎𑋏𑋐𑋑𑋒𑋓𑋔𑋕𑋖𑋗𑋘𑋙𑋚𑋛𑋜𑋝𑋞𑋟𑋠𑋡𑋢𑋣𑋤𑋥𑋦𑋧𑋨𑋩𑋪𑋫𑋬𑋭𑋮𑋯𑋰𑋱𑋲𑋳𑋴𑋵𑋶𑋷𑋸𑋹𑋺𑋻𑋼𑋽𑋾𑋿𑌀𑌁𑌂𑌃𑌄𑌅𑌆𑌇𑌈𑌉𑌊𑌋𑌌𑌍𑌎𑌏𑌐𑌑𑌒𑌓𑌔𑌕𑌖𑌗𑌘𑌙𑌚𑌛𑌜𑌝𑌞𑌟𑌠𑌡𑌢𑌣𑌤𑌥𑌦𑌧𑌨𑌩𑌪𑌫𑌬𑌭𑌮𑌯𑌰𑌱𑌲𑌳𑌴𑌵𑌶𑌷𑌸𑌹𑌺𑌻𑌼𑌽𑌾𑌿𑍀𑍁𑍂𑍃𑍄𑍅𑍆𑍇𑍈𑍉𑍊𑍋𑍌𑍍𑍎𑍏𑍐𑍑𑍒𑍓𑍔𑍕𑍖𑍗𑍘𑍙𑍚𑍛𑍜𑍝𑍞𑍟𑍠𑍡𑍢𑍣𑍤𑍥𑍦𑍧𑍨𑍩𑍪𑍫𑍬𑍭𑍮𑍯𑍰𑍱𑍲𑍳𑍴𑍵𑍶𑍷𑍸𑍹𑍺𑍻𑍼𑍽𑍾𑍿𑎀𑎁𑎂𑎃𑎄𑎅𑎆𑎇𑎈𑎉𑎊𑎋𑎌𑎍𑎎𑎏𑎐𑎑𑎒𑎓𑎔𑎕𑎖𑎗𑎘𑎙𑎚𑎛𑎜𑎝𑎞𑎟𑎠𑎡𑎢𑎣𑎤𑎥𑎦𑎧𑎨𑎩𑎪𑎫𑎬𑎭𑎮𑎯𑎰𑎱𑎲𑎳𑎴𑎵𑎶𑎷𑎸𑎹𑎺𑎻𑎼𑎽𑎾𑎿𑏀𑏁𑏂𑏃𑏄𑏅𑏆𑏇𑏈𑏉𑏊𑏋𑏌𑏍𑏎𑏏𑏐𑏑𑏒𑏓𑏔𑏕𑏖𑏗𑏘𑏙𑏚𑏛𑏜𑏝𑏞𑏟𑏠𑏡𑏢𑏣𑏤𑏥𑏦𑏧𑏨𑏩𑏪𑏫𑏬𑏭𑏮𑏯𑏰𑏱𑏲𑏳𑏴𑏵𑏶𑏷𑏸𑏹𑏺𑏻𑏼𑏽𑏾𑏿𑐀𑐁𑐂𑐃𑐄𑐅𑐆𑐇𑐈𑐉𑐊𑐋𑐌𑐍𑐎𑐏𑐐𑐑𑐒𑐓𑐔𑐕𑐖𑐗𑐘𑐙𑐚𑐛𑐜𑐝𑐞𑐟𑐠𑐡𑐢𑐣𑐤𑐥𑐦𑐧𑐨𑐩𑐪𑐫𑐬𑐭𑐮𑐯𑐰𑐱𑐲𑐳𑐴𑐵𑐶𑐷𑐸𑐹𑐺𑐻𑐼𑐽𑐾𑐿𑑀𑑁𑑂𑑃𑑄𑑅𑑆𑑇𑑈𑑉𑑊𑑋𑑌𑑍𑑎𑑏𑑐𑑑𑑒𑑓𑑔𑑕𑑖𑑗𑑘𑑙𑑚𑑛𑑜𑑝𑑞𑑟𑑠𑑡𑑢𑑣𑑤𑑥𑑦𑑧𑑨𑑩𑑪𑑫𑑬𑑭𑑮𑑯𑑰𑑱𑑲𑑳𑑴𑑵𑑶𑑷𑑸𑑹𑑺𑑻𑑼𑑽𑑾𑑿𑒀𑒁𑒂𑒃𑒄𑒅𑒆𑒇𑒈𑒉𑒊𑒋𑒌𑒍𑒎𑒏𑒐𑒑𑒒𑒓𑒔𑒕𑒖𑒗𑒘𑒙𑒚𑒛𑒜𑒝𑒞𑒟𑒠𑒡𑒢𑒣𑒤𑒥𑒦𑒧𑒨𑒩𑒪𑒫𑒬𑒭𑒮𑒯𑒰𑒱𑒲𑒳𑒴𑒵𑒶𑒷𑒸𑒻𑒻𑒼𑒽𑒾𑒿𑓀𑓁𑓃𑓂𑓄𑓅𑓆𑓇𑓈𑓉𑓊𑓋𑓌𑓍𑓎𑓏𑓐𑓑𑓒𑓓𑓔𑓕𑓖𑓗𑓘𑓙𑓚𑓛𑓜𑓝𑓞𑓟𑓠𑓡𑓢𑓣𑓤𑓥𑓦𑓧𑓨𑓩𑓪𑓫𑓬𑓭𑓮𑓯𑓰𑓱𑓲𑓳𑓴𑓵𑓶𑓷𑓸𑓹𑓺𑓻𑓼𑓽𑓾𑓿𑔀𑔁𑔂𑔃𑔄𑔅𑔆𑔇𑔈𑔉𑔊𑔋𑔌𑔍𑔎𑔏𑔐𑔑𑔒𑔓𑔔𑔕𑔖𑔗𑔘𑔙𑔚𑔛𑔜𑔝𑔞𑔟𑔠𑔡𑔢𑔣𑔤𑔥𑔦𑔧𑔨𑔩𑔪𑔫𑔬𑔭𑔮𑔯𑔰𑔱𑔲𑔳𑔴𑔵𑔶𑔷𑔸𑔹𑔺𑔻𑔼𑔽𑔾𑔿𑕀𑕁𑕂𑕃𑕄𑕅𑕆𑕇𑕈𑕉𑕊𑕋𑕌𑕍𑕎𑕏𑕐𑕑𑕒𑕓𑕔𑕕𑕖𑕗𑕘𑕙𑕚𑕛𑕜𑕝𑕞𑕟𑕠𑕡𑕢𑕣𑕤𑕥𑕦𑕧𑕨𑕩𑕪𑕫𑕬𑕭𑕮𑕯𑕰𑕱𑕲𑕳𑕴𑕵𑕶𑕷𑕸𑕹𑕺𑕻𑕼𑕽𑕾𑕿𑖀𑖁𑖂𑖃𑖄𑖅𑖆𑖇𑖈𑖉𑖊𑖋𑖌𑖍𑖎𑖏𑖐𑖑𑖒𑖓𑖔𑖕𑖖𑖗𑖘𑖙𑖚𑖛𑖜𑖝𑖞𑖟𑖠𑖡𑖢𑖣𑖤𑖥𑖦𑖧𑖨𑖩𑖪𑖫𑖬𑖭𑖮𑖯𑖰𑖱𑖲𑖳𑖴𑖵𑖶𑖷𑖸𑖹𑖺𑖻𑖼𑖽𑖾𑗀𑖿𑗁𑗂𑗃𑗄𑗅𑗆𑗇𑗈𑗉𑗊𑗋𑗌𑗍𑗎𑗏𑗐𑗑𑗒𑗓𑗔𑗕𑗖𑗗𑗘𑗙𑗚𑗛𑗜𑗝𑗞𑗟𑗠𑗡𑗢𑗣𑗤𑗥𑗦𑗧𑗨𑗩𑗪𑗫𑗬𑗭𑗮𑗯𑗰𑗱𑗲𑗳𑗴𑗵𑗶𑗷𑗸𑗹𑗺𑗻𑗼𑗽𑗾𑗿𑘀𑘁𑘂𑘃𑘄𑘅𑘆𑘇𑘈𑘉𑘊𑘋𑘌𑘍𑘎𑘏𑘐𑘑𑘒𑘓𑘔𑘕𑘖𑘗𑘘𑘙𑘚𑘛𑘜𑘝𑘞𑘟𑘠𑘡𑘢𑘣𑘤𑘥𑘦𑘧𑘨𑘩𑘪𑘫𑘬𑘭𑘮𑘯𑘰𑘱𑘲𑘳𑘴𑘵𑘶𑘷𑘸𑘹𑘺𑘻𑘼𑘽𑘾𑘿𑙀𑙁𑙂𑙃𑙄𑙅𑙆𑙇𑙈𑙉𑙊𑙋𑙌𑙍𑙎𑙏𑙐𑙑𑙒𑙓𑙔𑙕𑙖𑙗𑙘𑙙𑙚𑙛𑙜𑙝𑙞𑙟𑙠𑙡𑙢𑙣𑙤𑙥𑙦𑙧𑙨𑙩𑙪𑙫𑙬𑙭𑙮𑙯𑙰𑙱𑙲𑙳𑙴𑙵𑙶𑙷𑙸𑙹𑙺𑙻𑙼𑙽𑙾𑙿𑚀𑚁𑚂𑚃𑚄𑚅𑚆𑚇𑚈𑚉𑚊𑚋𑚌𑚍𑚎𑚏𑚐𑚑𑚒𑚓𑚔𑚕𑚖𑚗𑚘𑚙𑚚𑚛𑚜𑚝𑚞𑚟𑚠𑚡𑚢𑚣𑚤𑚥𑚦𑚧𑚨𑚩𑚪𑚫𑚬𑚭𑚮𑚯𑚰𑚱𑚲𑚳𑚴𑚵𑚷𑚶𑚸𑚹𑚺𑚻𑚼𑚽𑚾𑚿𑛀𑛁𑛂𑛃𑛄𑛅𑛆𑛇𑛈𑛉𑛊𑛋𑛌𑛍𑛎𑛏𑛐𑛑𑛒𑛓𑛔𑛕𑛖𑛗𑛘𑛙𑛚𑛛𑛜𑛝𑛞𑛟𑛠𑛡𑛢𑛣𑛤𑛥𑛦𑛧𑛨𑛩𑛪𑛫𑛬𑛭𑛮𑛯𑛰𑛱𑛲𑛳𑛴𑛵𑛶𑛷𑛸𑛹𑛺𑛻𑛼𑛽𑛾𑛿𑜀𑜁𑜂𑜃𑜄𑜅𑜆𑜇𑜈𑜉𑜊𑜋𑜌𑜍𑜎𑜏𑜐𑜑𑜒𑜓𑜔𑜕𑜖𑜗𑜘𑜙𑜚𑜛𑜜𑜝𑜞𑜟𑜠𑜡𑜢𑜣𑜤𑜥𑜦𑜧𑜨𑜩𑜪𑜫𑜬𑜭𑜮𑜯𑜰𑜱𑜲𑜳𑜴𑜵𑜶𑜷𑜸𑜹𑜺𑜻𑜼𑜽𑜾𑜿𑝀𑝁𑝂𑝃𑝄𑝅𑝆𑝇𑝈𑝉𑝊𑝋𑝌𑝍𑝎𑝏𑝐𑝑𑝒𑝓𑝔𑝕𑝖𑝗𑝘𑝙𑝚𑝛𑝜𑝝𑝞𑝟𑝠𑝡𑝢𑝣𑝤𑝥𑝦𑝧𑝨𑝩𑝪𑝫𑝬𑝭𑝮𑝯𑝰𑝱𑝲𑝳𑝴𑝵𑝶𑝷𑝸𑝹𑝺𑝻𑝼𑝽𑝾𑝿𑞀𑞁𑞂𑞃𑞄𑞅𑞆𑞇𑞈𑞉𑞊𑞋𑞌𑞍𑞎𑞏𑞐𑞑𑞒𑞓𑞔𑞕𑞖𑞗𑞘𑞙𑞚𑞛𑞜𑞝𑞞𑞟𑞠𑞡𑞢𑞣𑞤𑞥𑞦𑞧𑞨𑞩𑞪𑞫𑞬𑞭𑞮𑞯𑞰𑞱𑞲𑞳𑞴𑞵𑞶𑞷𑞸𑞹𑞺𑞻𑞼𑞽𑞾𑞿𑟀𑟁𑟂𑟃𑟄𑟅𑟆𑟇𑟈𑟉𑟊𑟋𑟌𑟍𑟎𑟏𑟐𑟑𑟒𑟓𑟔𑟕𑟖𑟗𑟘𑟙𑟚𑟛𑟜𑟝𑟞𑟟𑟠𑟡𑟢𑟣𑟤𑟥𑟦𑟧𑟨𑟩𑟪𑟫𑟬𑟭𑟮𑟯𑟰𑟱𑟲𑟳𑟴𑟵𑟶𑟷𑟸𑟹𑟺𑟻𑟼𑟽𑟾𑟿𑠀𑠁𑠂𑠃𑠄𑠅𑠆𑠇𑠈𑠉𑠊𑠋𑠌𑠍𑠎𑠏𑠐𑠑𑠒𑠓𑠔𑠕𑠖𑠗𑠘𑠙𑠚𑠛𑠜𑠝𑠞𑠟𑠠𑠡𑠢𑠣𑠤𑠥𑠦𑠧𑠨𑠩𑠪𑠫𑠬𑠭𑠮𑠯𑠰𑠱𑠲𑠳𑠴𑠵𑠶𑠷𑠸𑠺𑠹𑠻𑠼𑠽𑠾𑠿𑡀𑡁𑡂𑡃𑡄𑡅𑡆𑡇𑡈𑡉𑡊𑡋𑡌𑡍𑡎𑡏𑡐𑡑𑡒𑡓𑡔𑡕𑡖𑡗𑡘𑡙𑡚𑡛𑡜𑡝𑡞𑡟𑡠𑡡𑡢𑡣𑡤𑡥𑡦𑡧𑡨𑡩𑡪𑡫𑡬𑡭𑡮𑡯𑡰𑡱𑡲𑡳𑡴𑡵𑡶𑡷𑡸𑡹𑡺𑡻𑡼𑡽𑡾𑡿𑢀𑢁𑢂𑢃𑢄𑢅𑢆𑢇𑢈𑢉𑢊𑢋𑢌𑢍𑢎𑢏𑢐𑢑𑢒𑢓𑢔𑢕𑢖𑢗𑢘𑢙𑢚𑢛𑢜𑢝𑢞𑢟𑢠𑢡𑢢𑢣𑢤𑢥𑢦𑢧𑢨𑢩𑢪𑢫𑢬𑢭𑢮𑢯𑢰𑢱𑢲𑢳𑢴𑢵𑢶𑢷𑢸𑢹𑢺𑢻𑢼𑢽𑢾𑢿𑣀𑣁𑣂𑣃𑣄𑣅𑣆𑣇𑣈𑣉𑣊𑣋𑣌𑣍𑣎𑣏𑣐𑣑𑣒𑣓𑣔𑣕𑣖𑣗𑣘𑣙𑣚𑣛𑣜𑣝𑣞𑣟𑣠𑣡𑣢𑣣𑣤𑣥𑣦𑣧𑣨𑣩𑣪𑣫𑣬𑣭𑣮𑣯𑣰𑣱𑣲𑣳𑣴𑣵𑣶𑣷𑣸𑣹𑣺𑣻𑣼𑣽𑣾𑣿𑤀𑤁𑤂𑤃𑤄𑤅𑤆𑤇𑤈𑤉𑤊𑤋𑤌𑤍𑤎𑤏𑤐𑤑𑤒𑤓𑤔𑤕𑤖𑤗𑤘𑤙𑤚𑤛𑤜𑤝𑤞𑤟𑤠𑤡𑤢𑤣𑤤𑤥𑤦𑤧𑤨𑤩𑤪𑤫𑤬𑤭𑤮𑤯𑤰𑤱𑤲𑤳𑤴𑤵𑤶𑤷𑤸𑤹𑤺𑤻𑤼𑤽𑤾𑤿𑥀𑥁𑥂𑥃𑥄𑥅𑥆𑥇𑥈𑥉𑥊𑥋𑥌𑥍𑥎𑥏𑥐𑥑𑥒𑥓𑥔𑥕𑥖𑥗𑥘𑥙𑥚𑥛𑥜𑥝𑥞𑥟𑥠𑥡𑥢𑥣𑥤𑥥𑥦𑥧𑥨𑥩𑥪𑥫𑥬𑥭𑥮𑥯𑥰𑥱𑥲𑥳𑥴𑥵𑥶𑥷𑥸𑥹𑥺𑥻𑥼𑥽𑥾𑥿𑦀𑦁𑦂𑦃𑦄𑦅𑦆𑦇𑦈𑦉𑦊𑦋𑦌𑦍𑦎𑦏𑦐𑦑𑦒𑦓𑦔𑦕𑦖𑦗𑦘𑦙𑦚𑦛𑦜𑦝𑦞𑦟𑦠𑦡𑦢𑦣𑦤𑦥𑦦𑦧𑦨𑦩𑦪𑦫𑦬𑦭𑦮𑦯𑦰𑦱𑦲𑦳𑦴𑦵𑦶𑦷𑦸𑦹𑦺𑦻𑦼𑦽𑦾𑦿𑧀𑧁𑧂𑧃𑧄𑧅𑧆𑧇𑧈𑧉𑧊𑧋𑧌𑧍𑧎𑧏𑧐𑧑𑧒𑧓𑧔𑧕𑧖𑧗𑧘𑧙𑧚𑧛𑧜𑧝𑧞𑧟𑧠𑧡𑧢𑧣𑧤𑧥𑧦𑧧𑧨𑧩𑧪𑧫𑧬𑧭𑧮𑧯𑧰𑧱𑧲𑧳𑧴𑧵𑧶𑧷𑧸𑧹𑧺𑧻𑧼𑧽𑧾𑧿𑨀𑨁𑨂𑨃𑨄𑨅𑨆𑨇𑨈𑨉𑨊𑨋𑨌𑨍𑨎𑨏𑨐𑨑𑨒𑨓𑨔𑨕𑨖𑨗𑨘𑨙𑨚𑨛𑨜𑨝𑨞𑨟𑨠𑨡𑨢𑨣𑨤𑨥𑨦𑨧𑨨𑨩𑨪𑨫𑨬𑨭𑨮𑨯𑨰𑨱𑨲𑨳𑨴𑨵𑨶𑨷𑨸𑨹𑨺𑨻𑨼𑨽𑨾𑨿𑩀𑩁𑩂𑩃𑩄𑩅𑩆𑩇𑩈𑩉𑩊𑩋𑩌𑩍𑩎𑩏𑩐𑩑𑩒𑩓𑩔𑩕𑩖𑩗𑩘𑩙𑩚𑩛𑩜𑩝𑩞𑩟𑩠𑩡𑩢𑩣𑩤𑩥𑩦𑩧𑩨𑩩𑩪𑩫𑩬𑩭𑩮𑩯𑩰𑩱𑩲𑩳𑩴𑩵𑩶𑩷𑩸𑩹𑩺𑩻𑩼𑩽𑩾𑩿𑪀𑪁𑪂𑪃𑪄𑪅𑪆𑪇𑪈𑪉𑪊𑪋𑪌𑪍𑪎𑪏𑪐𑪑𑪒𑪓𑪔𑪕𑪖𑪗𑪘𑪙𑪚𑪛𑪜𑪝𑪞𑪟𑪠𑪡𑪢𑪣𑪤𑪥𑪦𑪧𑪨𑪩𑪪𑪫𑪬𑪭𑪮𑪯𑪰𑪱𑪲𑪳𑪴𑪵𑪶𑪷𑪸𑪹𑪺𑪻𑪼𑪽𑪾𑪿𑫀𑫁𑫂𑫃𑫄𑫅𑫆𑫇𑫈𑫉𑫊𑫋𑫌𑫍𑫎𑫏𑫐𑫑𑫒𑫓𑫔𑫕𑫖𑫗𑫘𑫙𑫚𑫛𑫜𑫝𑫞𑫟𑫠𑫡𑫢𑫣𑫤𑫥𑫦𑫧𑫨𑫩𑫪𑫫𑫬𑫭𑫮𑫯𑫰𑫱𑫲𑫳𑫴𑫵𑫶𑫷𑫸𑫹𑫺𑫻𑫼𑫽𑫾𑫿𑬀𑬁