




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, call 1-800-722-1471 (TTY: 1-800-842-5357) or visit us at [www.premera.com](http://www.premera.com). 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 1-800-722-1471 (TTY: 1-800-842-5357) to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	Calendar year aggregate <u>deductible</u> . \$2,500 Individual / \$5,000 Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Does not apply to <u>Preventive care</u> and services listed below as "No charge"	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$5,000 Individual / \$10,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premium</u> , <u>balance-billed</u> charges, penalties for failure to obtain <u>prior authorization</u> for services, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.premera.com">www.premera.com</a> or call 1-800-722-1471 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	40% <u>coinsurance</u> ( <u>deductible</u> does not apply)	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required for some outpatient imaging tests. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
<b>If you need drugs to treat your illness or condition</b>	Generic drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). No charge for specific preventive drugs. <u>Prior authorization</u> required for some drugs.
More information about <u>prescription drug coverage</u> is available at <a href="https://www.premera.com/documents/052148.pdf">https://www.premera.com/documents/052148.pdf</a>	Preferred brand drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). <u>Prior authorization</u> required for some drugs.
	Non-preferred brand drugs	20% <u>coinsurance</u>	20% <u>coinsurance</u> (retail), not covered (mail)	Covers up to a 90 day supply (retail and mail). <u>Prior authorization</u> required for some drugs.
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not covered	Covers up to a 30 day supply. Only covered at specific contracted specialty pharmacies. <u>Prior authorization</u> required for some drugs.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required for some services. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
	<u>Urgent care</u>	20% <u>coinsurance</u>	Hospital-based: 20% <u>coinsurance</u> Freestanding center: 40% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
<b>If you are pregnant</b>	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (such as, ultrasound).

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 130 visits per calendar year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 25 outpatient visits per calendar year, limited to 30 inpatient days per calendar year. Includes physical therapy, speech therapy, and occupational therapy. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 90 days per calendar year. <u>Prior authorization</u> required for all planned inpatient stays. Penalty for out-of-network: 50% of allowable charge to \$1,500 per stay.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Prior authorization</u> required to buy some medical equipment. Penalty for out-of-network: 50% of allowable charge to \$1,500 per occurrence.
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 240 respite hours, limited to 30 inpatient days - 6 month overall lifetime benefit limit, except when approved otherwise.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

## Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Chiropractic care or other spinal manipulations</li></ul>	<ul style="list-style-type: none"><li>• Foot care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>

**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: for ERISA plans, contact the Department of Labor's Employee Benefit's Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For governmental plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). For church plans and all other plans, call 1-800-562-6900 for the state insurance department, or the insurer at 1-800-722-1471 or TTY 1-800-842-5357. 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: your plan at 1-800-722-1471 or TTY 1-800-842-5357, or the state insurance department at 1-800-562-6900, or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

**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](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-722-1471.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-722-1471.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-722-1471.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-722-1471.

—————*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 \$2,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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>
---------------------------	-----------------

**In this example, Peg would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,560</b>

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

- The plan's overall deductible \$2,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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>
---------------------------	----------------

**In this example, Joe would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,120</b>

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

- The plan's overall deductible \$2,500
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**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>
---------------------------	----------------

**In this example, Mia would pay:**

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,500
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,560</b>

## Discrimination is Against the Law

Premera Blue Cross (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera 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: Civil Rights Coordinator — Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email [AppealsDepartmentInquiries@Premera.com](mailto:AppealsDepartmentInquiries@Premera.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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 Ave SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-722-1471 (TTY: 711).

**注意:** 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 800-722-1471 (TTY: 711)。

**CHU Ý:** Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-722-1471 (TTY: 711).

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-722-1471 (TTY: 711) 번으로 전화해 주십시오.

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-722-1471 (телетайп: 711).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.

Tumawag sa 800-722-1471 (TTY: 711).

**УВАГА!** Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 800-722-1471 (телетайп: 711).

**ប្រយ័ត្ន:** បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ

គឺអាចមានសំរាប់អ្នក។ ចូរទូរស័ព្ទ 800-722-1471 (TTY: 711)។

**注意事項:** 日本語を話される場合、無料の言語支援をご利用いただけます。800-722-1471 (TTY:711) まで、お電話にてご連絡ください。

**ማስታወሻ:** የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ-

800-722-1471 (መስማት ለተሳናቸው: 711)።

**XIYEEFFANNAA:** Afaan dubbattu Oroomiffa, tajaajjila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-722-1471 (TTY: 711).

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-722-1471 (رقم هاتف الصم والبكم: 711).

**ਧਿਆਨ ਦਿਓ:** ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤਾਮਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 800-722-1471

(TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

**ACHTUNG:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.

Rufnummer: 800-722-1471 (TTY: 711).

**ប្រែទឌ្ឍ:** វ៉ុ ១០ ១ ៣ ១៣៦ ១៣៧ ១៣៨ ១៣៩ ១៤០ ១៤១ ១៤២ ១៤៣ ១៤៤ ១៤៥ ១៤៦ ១៤៧ ១៤៨ ១៤៩ ១៥០ ១៥១ ១៥២ ១៥៣ ១៥៤ ១៥៥ ១៥៦ ១៥៧ ១៥៨ ១៥៩ ១៦០ ១៦១ ១៦២ ១៦៣ ១៦៤ ១៦៥ ១៦៦ ១៦៧ ១៦៨ ១៦៩ ១៧០ ១៧១ ១៧២ ១៧៣ ១៧៤ ១៧៥ ១៧៦ ១៧៧ ១៧៨ ១៧៩ ១៨០ ១៨១ ១៨២ ១៨៣ ១៨៤ ១៨៥ ១៨៦ ១៨៧ ១៨៨ ១៨៩ ១៩០ ១៩១ ១៩២ ១៩៣ ១៩៤ ១៩៥ ១៩៦ ១៩៧ ១៩៨ ១៩៩ ២០០ ២០១ ២០២ ២០៣ ២០៤ ២០៥ ២០៦ ២០៧ ២០៨ ២០៩ ២១០ ២១១ ២១២ ២១៣ ២១៤ ២១៥ ២១៦ ២១៧ ២១៨ ២១៩ ២២០ ២២១ ២២២ ២២៣ ២២៤ ២២៥ ២២៦ ២២៧ ២២៨ ២២៩ ២៣០ ២៣១ ២៣២ ២៣៣ ២៣៤ ២៣៥ ២៣៦ ២៣៧ ២៣៨ ២៣៩ ២៤០ ២៤១ ២៤២ ២៤៣ ២៤៤ ២៤៥ ២៤៦ ២៤៧ ២៤៨ ២៤៩ ២៥០ ២៥១ ២៥២ ២៥៣ ២៥៤ ២៥៥ ២៥៦ ២៥៧ ២៥៨ ២៥៩ ២៦០ ២៦១ ២៦២ ២៦៣ ២៦៤ ២៦៥ ២៦៦ ២៦៧ ២៦៨ ២៦៩ ២៧០ ២៧១ ២៧២ ២៧៣ ២៧៤ ២៧៥ ២៧៦ ២៧៧ ២៧៨ ២៧៩ ២៨០ ២៨១ ២៨២ ២៨៣ ២៨៤ ២៨៥ ២៨៦ ២៨៧ ២៨៨ ២៨៩ ២៩០ ២៩១ ២៩២ ២៩៣ ២៩៤ ២៩៥ ២៩៦ ២៩៧ ២៩៨ ២៩៩ ៣០០ ៣០១ ៣០២ ៣០៣ ៣០៤ ៣០៥ ៣០៦ ៣០៧ ៣០៨ ៣០៩ ៣១០ ៣១១ ៣១២ ៣១៣ ៣១៤ ៣១៥ ៣១៦ ៣១៧ ៣១៨ ៣១៩ ៣២០ ៣២១ ៣២២ ៣២៣ ៣២៤ ៣២៥ ៣២៦ ៣២៧ ៣២៨ ៣២៩ ៣៣០ ៣៣១ ៣៣២ ៣៣៣ ៣៣៤ ៣៣៥ ៣៣៦ ៣៣៧ ៣៣៨ ៣៣៩ ៣៤០ ៣៤១ ៣៤២ ៣៤៣ ៣៤៤ ៣៤៥ ៣៤៦ ៣៤៧ ៣៤៨ ៣៤៩ ៣៥០ ៣៥១ ៣៥២ ៣៥៣ ៣៥៤ ៣៥៥ ៣៥៦ ៣៥៧ ៣៥៨ ៣៥៩ ៣៦០ ៣៦១ ៣៦២ ៣៦៣ ៣៦៤ ៣៦៥ ៣៦៦ ៣៦៧ ៣៦៨ ៣៦៩ ៣៧០ ៣៧១ ៣៧២ ៣៧៣ ៣៧៤ ៣៧៥ ៣៧៦ ៣៧៧ ៣៧៨ ៣៧៩ ៣៨០ ៣៨១ ៣៨២ ៣៨៣ ៣៨៤ ៣៨៥ ៣៨៦ ៣៨៧ ៣៨៨ ៣៨៩ ៣៩០ ៣៩១ ៣៩២ ៣៩៣ ៣៩៤ ៣៩៥ ៣៩៦ ៣៩៧ ៣៩៨ ៣៩៩ ៤០០ ៤០១ ៤០២ ៤០៣ ៤០៤ ៤០៥ ៤០៦ ៤០៧ ៤០៨ ៤០៩ ៤១០ ៤១១ ៤១២ ៤១៣ ៤១៤ ៤១៥ ៤១៦ ៤១៧ ៤១៨ ៤១៩ ៤២០ ៤២១ ៤២២ ៤២៣ ៤២៤ ៤២៥ ៤២៦ ៤២៧ ៤២៨ ៤២៩ ៤៣០ ៤៣១ ៤៣២ ៤៣៣ ៤៣៤ ៤៣៥ ៤៣៦ ៤៣៧ ៤៣៨ ៤៣៩ ៤៤០ ៤៤១ ៤៤២ ៤៤៣ ៤៤៤ ៤៤៥ ៤៤៦ ៤៤៧ ៤៤៨ ៤៤៩ ៤៥០ ៤៥១ ៤៥២ ៤៥៣ ៤៥៤ ៤៥៥ ៤៥៦ ៤៥៧ ៤៥៨ ៤៥៩ ៤៦០ ៤៦១ ៤៦២ ៤៦៣ ៤៦៤ ៤៦៥ ៤៦៦ ៤៦៧ ៤៦៨ ៤៦៩ ៤៧០ ៤៧១ ៤៧២ ៤៧៣ ៤៧៤ ៤៧៥ ៤៧៦ ៤៧៧ ៤៧៨ ៤៧៩ ៤៨០ ៤៨១ ៤៨២ ៤៨៣ ៤៨៤ ៤៨៥ ៤៨៦ ៤៨៧ ៤៨៨ ៤៨៩ ៤៩០ ៤៩១ ៤៩២ ៤៩៣ ៤៩៤ ៤៩៥ ៤៩៦ ៤៩៧ ៤៩៨ ៤៩៩ ៥០០ ៥០១ ៥០២ ៥០៣ ៥០៤ ៥០៥ ៥០៦ ៥០៧ ៥០៨ ៥០៩ ៥១០ ៥១១ ៥១២ ៥១៣ ៥១៤ ៥១៥ ៥១៦ ៥១៧ ៥១៨ ៥១៩ ៥២០ ៥២១ ៥២២ ៥២៣ ៥២៤ ៥២៥ ៥២៦ ៥២៧ ៥២៨ ៥២៩ ៥៣០ ៥៣១ ៥៣២ ៥៣៣ ៥៣៤ ៥៣៥ ៥៣៦ ៥៣៧ ៥៣៨ ៥៣៩ ៥៤០ ៥៤១ ៥៤២ ៥៤៣ ៥៤៤ ៥៤៥ ៥៤៦ ៥៤៧ ៥៤៨ ៥៤៩ ៥៥០ ៥៥១ ៥៥២ ៥៥៣ ៥៥៤ ៥៥៥ ៥៥៦ ៥៥៧ ៥៥៨ ៥៥៩ ៥៦០ ៥៦១ ៥៦២ ៥៦៣ ៥៦៤ ៥៦៥ ៥៦៦ ៥៦៧ ៥៦៨ ៥៦៩ ៥៧០ ៥៧១ ៥៧២ ៥៧៣ ៥៧៤ ៥៧៥ ៥៧៦ ៥៧៧ ៥៧៨ ៥៧៩ ៥៨០ ៥៨១ ៥៨២ ៥៨៣ ៥៨៤ ៥៨៥ ៥៨៦ ៥៨៧ ៥៨៨ ៥៨៩ ៥៩០ ៥៩១ ៥៩២ ៥៩៣ ៥៩៤ ៥៩៥ ៥៩៦ ៥៩៧ ៥៩៨ ៥៩៩ ៦០០ ៦០១ ៦០២ ៦០៣ ៦០៤ ៦០៥ ៦០៦ ៦០៧ ៦០៨ ៦០៩ ៦១០ ៦១១ ៦១២ ៦១៣ ៦១៤ ៦១៥ ៦១៦ ៦១៧ ៦១៨ ៦១៩ ៦២០ ៦២១ ៦២២ ៦២៣ ៦២៤ ៦២៥ ៦២៦ ៦២៧ ៦២៨ ៦២៩ ៦៣០ ៦៣១ ៦៣២ ៦៣៣ ៦៣៤ ៦៣៥ ៦៣៦ ៦៣៧ ៦៣៨ ៦៣៩ ៦៤០ ៦៤១ ៦៤២ ៦៤៣ ៦៤៤ ៦៤៥ ៦៤៦ ៦៤៧ ៦៤៨ ៦៤៩ ៦៥០ ៦៥១ ៦៥២ ៦៥៣ ៦៥៤ ៦៥៥ ៦៥៦ ៦៥៧ ៦៥៨ ៦៥៩ ៦៦០ ៦៦១ ៦៦២ ៦៦៣ ៦៦៤ ៦៦៥ ៦៦៦ ៦៦៧ ៦៦៨ ៦៦៩ ៦៧០ ៦៧១ ៦៧២ ៦៧៣ ៦៧៤ ៦៧៥ ៦៧៦ ៦៧៧ ៦៧៨ ៦៧៩ ៦៨០ ៦៨១ ៦៨២ ៦៨៣ ៦៨៤ ៦៨៥ ៦៨៦ ៦៨៧ ៦៨៨ ៦៨៩ ៦៩០ ៦៩១ ៦៩២ ៦៩៣ ៦៩៤ ៦៩៥ ៦៩៦ ៦៩៧ ៦៩៨ ៦៩៩ ៧០០ ៧០១ ៧០២ ៧០៣ ៧០៤ ៧០៥ ៧០៦ ៧០៧ ៧០៨ ៧០៩ ៧១០ ៧១១ ៧១២ ៧១៣ ៧១៤ ៧១៥ ៧១៦ ៧១៧ ៧១៨ ៧១៩ ៧២០ ៧២១ ៧២២ ៧២៣ ៧២៤ ៧២៥ ៧២៦ ៧២៧ ៧២៨ ៧២៩ ៧៣០ ៧៣១ ៧៣២ ៧៣៣ ៧៣៤ ៧៣៥ ៧៣៦ ៧៣៧ ៧៣៨ ៧៣៩ ៧៤០ ៧៤១ ៧៤២ ៧៤៣ ៧៤៤ ៧៤៥ ៧៤៦ ៧៤៧ ៧៤៨ ៧៤៩ ៧៥០ ៧៥១ ៧៥២ ៧៥៣ ៧៥៤ ៧៥៥ ៧៥៦ ៧៥៧ ៧៥៨ ៧៥៩ ៧៦០ ៧៦១ ៧៦២ ៧៦៣ ៧៦៤ ៧៦៥ ៧៦៦ ៧៦៧ ៧៦៨ ៧៦៩ ៧៧០ ៧៧១ ៧៧២ ៧៧៣ ៧៧៤ ៧៧៥ ៧៧៦ ៧៧៧ ៧៧៨ ៧៧៩ ៧៨០ ៧៨១ ៧៨២ ៧៨៣ ៧៨៤ ៧៨៥ ៧៨៦ ៧៨៧ ៧៨៨ ៧៨៩ ៧៩០ ៧៩១ ៧៩២ ៧៩៣ ៧៩៤ ៧៩៥ ៧៩៦ ៧៩៧ ៧៩៨ ៧៩៩ ៨០០ ៨០១ ៨០២ ៨០៣ ៨០៤ ៨០៥ ៨០៦ ៨០៧ ៨០៨ ៨០៩ ៨១០ ៨១១ ៨១២ ៨១៣ ៨១៤ ៨១៥ ៨១៦ ៨១៧ ៨១៨ ៨១៩ ៨២០ ៨២១ ៨២២ ៨២៣ ៨២៤ ៨២៥ ៨២៦ ៨២៧ ៨២៨ ៨២៩ ៨៣០ ៨៣១ ៨៣២ ៨៣៣ ៨៣៤ ៨៣៥ ៨៣៦ ៨៣៧ ៨៣៨ ៨៣៩ ៨៤០ ៨៤១ ៨៤២ ៨៤៣ ៨៤៤ ៨៤៥ ៨៤៦ ៨៤៧ ៨៤៨ ៨៤៩ ៨៥០ ៨៥១ ៨៥២ ៨៥៣ ៨៥៤ ៨៥៥ ៨៥៦ ៨៥៧ ៨៥៨ ៨៥៩ ៨៦០ ៨៦១ ៨៦២ ៨៦៣ ៨៦៤ ៨៦៥ ៨៦៦ ៨៦៧ ៨៦៨ ៨៦៩ ៨៧០ ៨៧១ ៨៧២ ៨៧៣ ៨៧៤ ៨៧៥ ៨៧៦ ៨៧៧ ៨៧៨ ៨៧៩ ៨៨០ ៨៨១ ៨៨២ ៨៨៣ ៨៨៤ ៨៨៥ ៨៨៦ ៨៨៧ ៨៨៨ ៨៨៩ ៨៩០ ៨៩១ ៨៩២ ៨៩៣ ៨៩៤ ៨៩៥ ៨៩៦ ៨៩៧ ៨៩៨ ៨៩៩ ៩០០ ៩០១ ៩០២ ៩០៣ ៩០៤ ៩០៥ ៩០៦ ៩០៧ ៩០៨ ៩០៩ ៩១០ ៩១១ ៩១២ ៩១៣ ៩១៤ ៩១៥ ៩១៦ ៩១៧ ៩១៨ ៩១៩ ៩២០ ៩២១ ៩២២ ៩២៣ ៩២៤ ៩២៥ ៩២៦ ៩២៧ ៩២៨ ៩២៩ ៩៣០ ៩៣១ ៩៣២ ៩៣៣ ៩៣៤ ៩៣៥ ៩៣៦ ៩៣៧ ៩៣៨ ៩៣៩ ៩៤០ ៩៤១ ៩៤២ ៩៤៣ ៩៤៤ ៩៤៥ ៩៤៦ ៩៤៧ ៩៤៨ ៩៤៩ ៩៥០ ៩៥១ ៩៥២ ៩៥៣ ៩៥៤ ៩៥៥ ៩៥៦ ៩៥៧ ៩៥៨ ៩៥៩ ៩៦០ ៩៦១ ៩៦២ ៩៦៣ ៩៦៤ ៩៦៥ ៩៦៦ ៩៦៧ ៩៦៨ ៩៦៩ ៩៧០ ៩៧១ ៩៧២ ៩៧៣ ៩៧៤ ៩៧៥ ៩៧៦ ៩៧៧ ៩៧៨ ៩៧៩ ៩៨០ ៩៨១ ៩៨២ ៩៨៣ ៩៨៤ ៩៨៥ ៩៨៦ ៩៨៧ ៩៨៨ ៩៨៩ ៩៩០ ៩៩១ ៩៩២ ៩៩៣ ៩៩៤ ៩៩៥ ៩៩៦ ៩៩៧ ៩៩៨ ៩៩៩ ១០០០ ១០០១ ១០០២ ១០០៣ ១០០៤ ១០០៥ ១០០៦ ១០០៧ ១០០៨ ១០០៩ ១០១០ ១០១១ ១០១២ ១០១៣ ១០១៤ ១០១៥ ១០១៦ ១០១៧ ១០១៨ ១០១៩ ១០២០ ១០២១ ១០២២ ១០២៣ ១០២៤ ១០២៥ ១០២៦ ១០២៧ ១០២៨ ១០២៩ ១០៣០ ១០៣១ ១០៣២ ១០៣៣ ១០៣៤ ១០៣៥ ១០៣៦ ១០៣៧ ១០៣៨ ១០៣៩ ១០៤០ ១០៤១ ១០៤២ ១០៤៣ ១០៤៤ ១០៤៥ ១០៤៦ ១០៤៧ ១០៤៨ ១០៤៩ ១០៥០ ១០៥១ ១០៥២ ១០៥៣ ១០៥៤ ១០៥៥ ១០៥៦ ១០៥៧ ១០៥៨ ១០៥៩ ១០៦០ ១០៦១ ១០៦២ ១០៦៣ ១០៦៤ ១០៦៥ ១០៦៦ ១០៦៧ ១០៦៨ ១០៦៩ ១០៧០ ១០៧១ ១០៧២ ១០៧៣ ១០៧៤ ១០៧៥ ១០៧៦ ១០៧៧ ១០៧៨ ១០៧៩ ១០៨០ ១០៨១ ១០៨២ ១០៨៣ ១០៨៤ ១០៨៥ ១០៨៦ ១០៨៧ ១០៨៨ ១០៨៩ ១០៩០ ១០៩១ ១០៩២ ១០៩៣ ១០៩៤ ១០៩៥ ១០៩៦ ១០៩៧ ១០៩៨ ១០៩៩ ១១០០ ១១០១ ១១០២ ១១០៣ ១១០៤ ១១០៥ ១១០៦ ១១០៧ ១១០៨ ១១០៩ ១១១០ ១១១១ ១១១២ ១១១៣ ១១១៤ ១១១៥ ១១១៦ ១១១៧ ១១១៨ ១១១៩ ១១២០ ១១២១ ១១២២ ១១២៣ ១១២៤ ១១២៥ ១១២៦ ១១២៧ ១១២៨ ១១២៩ ១១៣០ ១១៣១ ១១៣២ ១១៣៣ ១១៣៤ ១១៣៥ ១១៣៦ ១១៣៧ ១១៣៨ ១១៣៩ ១១៤០ ១១៤១ ១១៤២ ១១៤៣ ១១៤៤ ១១៤៥ ១១៤៦ ១១៤៧ ១១៤៨ ១១៤៩ ១១៥០ ១១៥១ ១១៥២ ១១៥៣ ១១៥៤ ១១៥៥ ១១៥៦ ១១៥៧ ១១៥៨ ១១៥៩ ១១៦០ ១១៦១ ១១៦២ ១១៦៣ ១១៦៤ ១១៦៥ ១១៦៦ ១១៦៧ ១១៦៨ ១១៦៩ ១១៧០ ១១៧១ ១១៧២ ១១៧៣ ១១៧៤ ១១៧៥ ១១៧៦ ១១៧៧ ១១៧៨ ១១៧៩ ១១៨០ ១១៨១ ១១៨២ ១១៨៣ ១១៨៤ ១១៨៥ ១១៨៦ ១១៨៧ ១១៨៨ ១១៨៩ ១១៩០ ១១៩១ ១១៩២ ១១៩៣ ១១៩៤ ១១៩៥ ១១៩៦ ១១៩៧ ១១៩៨ ១១៩៩ ១២០០ ១២០១ ១២០២ ១២០៣ ១២០៤ ១២០៥ ១២០៦ ១២០៧ ១២០៨ ១២០៩ ១២១០ ១២១១ ១២១២ ១២១៣ ១២១៤ ១២១៥ ១២១៦ ១២១៧ ១២១៨ ១២១៩ ១២២០ ១២២១ ១២២២ ១២២៣ ១២២៤ ១២២៥ ១២២៦ ១២២៧ ១២២៨ ១២២៩ ១២៣០ ១២៣១ ១២៣២ ១២៣៣ ១២៣៤ ១២៣៥ ១២៣៦ ១២៣៧ ១២៣៨ ១២៣៩ ១២៤០ ១២៤១ ១២៤២ ១២៤៣ ១២៤៤ ១២៤៥ ១២៤៦ ១២៤៧ ១២៤៨ ១២៤៩ ១២៥០ ១២៥១ ១២៥២ ១២៥៣ ១២៥៤ ១២៥៥ ១២៥៦ ១២៥៧ ១២៥៨ ១២៥៩ ១២៦០ ១២៦១ ១២៦២ ១២៦៣ ១២៦៤ ១២៦៥ ១២៦៦ ១២៦៧ ១២៦៨ ១២៦៩ ១២៧០ ១២៧១ ១២៧២ ១២៧៣ ១២៧៤ ១២៧៥ ១២៧៦ ១២៧៧ ១២៧៨ ១២៧៩ ១២៨០ ១២៨១ ១២៨២ ១២៨៣ ១២៨៤ ១២៨៥ ១២៨៦ ១២៨៧ ១២៨៨ ១២៨៩ ១២៩០ ១២៩១ ១២៩២ ១២៩៣ ១២៩៤ ១២៩៥ ១២៩៦ ១២៩៧ ១២៩៨ ១២៩៩ ១៣០០ ១៣០១ ១៣០២ ១៣០៣ ១៣០៤ ១៣០៥ ១៣០៦ ១៣០៧ ១៣០៨ ១៣០៩ ១៣១០ ១៣១១ ១៣១២ ១៣១៣ ១៣១៤ ១៣១៥ ១៣១៦ ១៣១៧ ១៣១៨ ១៣១៩ ១៣២០ ១៣២១ ១៣២២ ១៣២៣ ១៣២៤ ១៣២៥ ១៣២៦ ១៣២៧ ១៣២៨ ១៣២៩ ១៣៣០ ១៣៣១ ១៣៣២ ១៣៣៣ ១៣៣៤ ១៣៣៥ ១៣៣៦ ១៣៣៧ ១៣៣៨ ១៣៣៩ ១៣៤០ ១៣៤១ ១៣៤២ ១៣៤៣ ១៣៤៤ ១៣៤៥ ១៣៤៦ ១៣៤៧ ១៣៤៨ ១៣៤៩ ១៣៥០ ១៣៥១ ១៣៥២ ១៣៥៣ ១៣៥៤ ១៣៥៥ ១៣៥៦ ១៣៥៧ ១៣៥៨ ១៣៥៩ ១៣៦០ ១៣៦១ ១៣៦២ ១៣៦៣ ១៣៦៤ ១៣៦៥ ១៣៦៦ ១៣៦៧ ១៣៦៨ ១៣៦៩ ១៣៧០ ១៣៧១ ១៣៧២ ១៣៧៣ ១៣៧៤ ១៣៧៥ ១៣៧៦ ១៣៧៧ ១៣៧៨ ១៣៧៩ ១៣៨០ ១៣៨១ ១៣៨២ ១៣៨៣ ១៣៨៤ ១៣៨៥ ១៣៨៦ ១៣៨៧ ១៣៨៨ ១៣៨៩ ១៣៩០ ១៣៩១ ១៣៩២ ១៣៩៣ ១៣៩៤ ១៣៩៥ ១៣៩៦ ១៣៩៧ ១៣៩៨ ១៣៩៩ ១៤០០ ១៤០១ ១៤០២ ១៤០៣ ១៤០៤ ១៤០៥ ១៤០៦ ១៤០៧ ១៤០៨ ១៤០៩ ១៤១០ ១៤១១ ១៤១២ ១៤១៣ ១៤១៤ ១៤១៥ ១៤១៦ ១៤១៧ ១៤១៨ ១៤១៩ ១៤២០ ១៤២១ ១៤២២ ១៤២៣ ១៤២៤ ១៤២៥ ១៤២៦ ១៤២៧ ១៤២៨ ១៤២៩ ១៤៣០ ១៤៣១ ១៤៣២ ១៤៣៣ ១៤៣៤ ១៤៣៥ ១៤៣៦ ១៤៣៧ ១៤៣៨ ១៤៣៩ ១៤៤០ ១៤៤១ ១៤៤២ ១៤៤៣ ១៤៤៤ ១៤៤៥ ១៤៤៦ ១៤៤៧ ១៤៤៨ ១៤