



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, coverage, you may access your summary plan description at https://totalrewards.northropgrumman.com/download/file_library/146/NGHPSPD_2021.pdf.

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 (800) 894-1374 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|--|
| What is the overall <u>deductible</u>? | \$1,100 /employee or \$1,600 /employee + spouse or \$1,600 /employee + children or \$2,100 /employee + family. All <u>Providers</u> . | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the policy, the overall family <u>deductible</u> must be met before the plan begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | Yes. <u>Prescription Drugs</u> and <u>Preventive care</u> for In- <u>Network</u> and <u>Out-of-Network Providers</u> and telemedicine visits with Live Health Online. | This plan 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 plan covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this plan? | \$4,000 /employee or \$6,000 /employee + spouse or \$6,000 /employee + children or \$8,000 /employee + family. All <u>Providers</u> . | 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 plan , 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. |
| What is not included in the <u>out-of-pocket limit</u> ? | Services deemed not medically necessary by Medical Management and/or Anthem, <u>Premiums</u> , <u>balance-billing</u> charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| | | |
|--|--|--|
| Will you pay less if you use a <u>network provider</u>? | Yes, Blue Card PPO. See www.anthem.com/ca or call (800) 894-1374 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u>? | 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 |
|--|--|---|--|--|
| | | In-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 | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | <u>Coinsurance</u> applies to both in-person and virtual visits with your <u>provider</u> . You pay a \$10 <u>copay</u> for each telemedicine visit with LiveHealth Online. |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | <u>Preventive care/screening/immunization</u> | No charge | No charge | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | Imaging (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Costs may vary by site of service. Please check with your <u>plan</u> for details. |
| If you need drugs to treat your illness or condition | Generic Drugs | 20% <u>coinsurance</u> (retail) and 20% <u>coinsurance</u> up to a \$200 maximum/prescription (home delivery) | 50% <u>coinsurance</u> (retail) | Limited to a 30 day supply at retail or 90 day supply through mail order/CVS Pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or CVS pharmacy. Please check with your <u>plan</u> |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|---|--|---|
| | | In-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 www.caremark.com | | | | for details. Medical <u>Deductible</u> does not apply. |
| | <u>Formulary</u> Brand Name Drugs | 20% <u>coinsurance</u> (retail) and 20% <u>coinsurance</u> up to a \$200 maximum/prescription (home delivery) | 50% <u>coinsurance</u> (retail) | Limited to a 30 day supply at retail or 90 day supply through mail order/CVS Pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or CVS pharmacy. Please check with your <u>plan</u> for details. Medical <u>Deductible</u> does not apply. |
| | Non- <u>Formulary</u> Brand Name Drugs | 35% <u>coinsurance</u> (retail) and 35% <u>coinsurance</u> up to a \$200 maximum/prescription (home delivery) | 50% <u>coinsurance</u> (retail) | Limited to a 30 day supply at retail or 90 day supply through mail order/CVS Pharmacy. Chemically equivalent generics, if available are required. Maintenance medications are required to be obtained via mail order or CVS pharmacy. Please check with your <u>plan</u> for details. Medical <u>Deductible</u> does not apply. |
| | <u>Specialty drugs</u> | 20% <u>coinsurance</u> up to a \$200 maximum /prescription | Not covered | Medical <u>Deductible</u> does not apply. Check with <u>plan</u> for details. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | Covered as In- <u>Network</u> | 20% <u>coinsurance</u> for Emergency Room Physician Fee. Failure to obtain pre-authorization for Emergency admission (require notification no later than 72 business hours after admission) may result in non-coverage |
| | Emergency medical transportation | 20% <u>coinsurance</u> | Covered as In- <u>Network</u> | Failure to obtain preauthorization for air ambulance may result in non-coverage |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | You pay a \$10 <u>copay</u> /visit for each telemedicine visit with LiveHealth Online. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Failure to obtain pre-authorization may result in a penalty of \$500 |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Office Visit 20% <u>coinsurance</u> Other Outpatient 20% <u>coinsurance</u> | Office Visit 50% <u>coinsurance</u> Other Outpatient 50% <u>coinsurance</u> | Office Visit <u>Coinsurance</u> applies to both in-person and virtual visits with your provider. Other Outpatient -----none----- |
| | Inpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 20% <u>coinsurance</u> for Inpatient Physician Fee In- <u>Network Providers</u> . 50% <u>coinsurance</u> for Inpatient Physician Fee <u>Out-of-Network Providers</u> . Failure to obtain pre-authorization may result in a penalty of \$500. |
| If you are pregnant | Office visits | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Failure to obtain pre-authorization may result in a penalty of \$500 for inpatient stay that exceeds 48 hours of normal delivery and 96 hours after a cesarean delivery. |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 100 visits/benefit period including private duty nursing in and out of network combined. Failure to obtain pre-authorization may result in a penalty of \$500 |
| | <u>Rehabilitation services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | -----none----- |
| | <u>Habilitation services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|----------------------------------|---|--|--|
| | | In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | <u>Skilled nursing care</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 100 visits/benefit period including private duty nursing in and out of network combined. Failure to obtain pre-authorization may result in a penalty of \$500. |
| | <u>Durable medical equipment</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Includes two hearing aids/benefit year. Wigs and toupees are limited to \$1500/benefit year. One pair of custom shoes or custom molded inserts prescribed by a physician per benefit year. |
| | <u>Hospice services</u> | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Failure to obtain pre-authorization may result in non-coverage. Respite care and bereavement are excluded. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | -----none----- |
| | Children's glasses | Not covered | Not covered | |
| | Children's dental check-up | Not covered | Not covered | |

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 <u>excluded services</u>.) | | |
|--|--|--|
| <ul style="list-style-type: none"> • Cosmetic surgery • Routine eye care (adult) • Weight loss programs | <ul style="list-style-type: none"> • Dental care (adult) • Routine foot care unless you have been diagnosed with diabetes. | <ul style="list-style-type: none"> • Dental Check-up • Long- term care |

| 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"> • Abortion • Chiropractic care 24 visits/benefit period. • Most coverage provided outside the United States. See www.bcbsglobalcore.com | <ul style="list-style-type: none"> • Acupuncture 12 visits/benefit period. • Hearing aids two/benefit Period. • Private-duty nursing covered in the home. 100 visits/benefit period including <u>home health care</u>. | <ul style="list-style-type: none"> • Bariatric surgery • Infertility treatment \$25,000 maximum/lifetime. |

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

ATTN: Grievances and Appeals, PO Box 54159, Los Angeles, CA 90054-0159

Department of Labor, Employee Benefits Security Administration, (866) 444-EBSA (3272), 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 plan 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 plan 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 plan's overall deductible \$1,100
- 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*)

| | |
|--------------------|----------|
| Total Example Cost | \$12,840 |
|--------------------|----------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$2,336 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$3,496 |

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

- The plan's overall deductible \$1,100
- 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*)

| | |
|--------------------|---------|
| Total Example Cost | \$7,460 |
|--------------------|---------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,261 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$2,416 |

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

- The plan's overall deductible \$1,100
- 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*)

| | |
|--------------------|---------|
| Total Example Cost | \$2,010 |
|--------------------|---------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$1,100 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$182 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,282 |

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 (800) 894-1374

Amharic (አማርኛ):- ስለዚህ ሰነድ ማንኛውም ጥያቄ ካለዎት በራስዎ ቋንቋ እርዳታ እና ይህን መረጃ በገጽ የማግኘት መብት አለዎት። አስተርጓሚ ለማናገር (800) 894-1374 ይደውሉ።

Arabic (العربية): إذا كان لديك أي استفسارات بشأن هذا المستند، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون مقابل. للتحدث إلى مترجم، اتصل على (800) 894-1374.

Armenian (հայերեն). Եթե այս փաստաթղթի հետ կապված հարցեր ունեք, դուք իրավունք ունեք անվճար ստանալ օգնություն և տեղեկատվություն ձեր լեզվով: Թարգմանչի հետ խոսելու համար զանգահարեք հետևյալ հեռախոսահամարով՝ (800) 894-1374:

Bassa (Bàsɔ̀ wùdù): M̄ dyi dyi-diè-dè b̄é b̄édé b̄á céè-dè n̄ià ke dyí ní, ɔ̀ m̄ò n̄i dyí-b̄èdè̀n-dè b̄é m̄ ké gbo-kpá-kpá kè b̄ǎ kp̄ɔ̀ dé m̄ bídí-wùdù̀n b̄ó pídyi. B̄é m̄ ké wuɖu-zìin-nyò d̄ò gbo wùdù̀ ke, d̄á (800) 894-1374.

Bengali (বাংলা): যদি এই নথিপত্রের বিষয়ে আপনার কোনো প্রশ্ন থাকে, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য পাওয়ার ও তথ্য পাওয়ার অধিকার আপনার আছে। একজন দোভাষীর সাথে কথা বলার জন্য (800) 894-1374 -তে কল করুন।

Burmese (မြန်မာ): ဤစာရွက်စာတမ်းနှင့် ပတ်သက်၍ သင့်တွင် မေးမြန်းလိုသည်များရှိပါက အချက်အလက်များနှင့် အကူအညီကို အခကြေးငွေ ပေးစရာမလိုပဲ သင့်ဘာသာစကားဖြင့် ရယူနိုင်ခွင့် သင့်တွင် ရှိပါသည်။ စကားပြန် တစ်ဦးနှင့် စကားပြောနိုင်ရန် ဖုန်း (800) 894-1374 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 (800) 894-1374。

Dinka (Dinka): Na nɔŋ thiëc nē ke de yā thorē, ke yin nɔŋ loŋ bē yi kuony ku wēr alēu bē gēer yic yin ne thoŋ du ke cin wēu tāāuē ke piny. Te kōr yin ba jam wēnē ran ye thok geryic, ke yin cəl (800) 894-1374.

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 (800) 894-1374.

Farsi (فارسی): 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 (800) 894-1374 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 (800) 894-1374.

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 (800) 894-1374.

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 (800) 894-1374.

Gujarati (ગુજરાતી): જો આ દસ્તાવેજ અંગે આપને કોઈપણ પ્રશ્નો હોય તો, કોઈપણ ખર્ચ વગર આપની ભાષામાં મદદ અને માહિતી મેળવવાનો તમને અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે, કોલ કરો (800) 894-1374.

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 (800) 894-1374.

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 (800) 894-1374 ।

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 (800) 894-1374.

Igbo (Igbo): Ọ bụr ụ na ị nwere ajụjụ ọ bụla gbasara akwụkwọ a, ị nwere ikike ịnweta enyemaka na ozi n'asụsụ gị na akwụghị ụgwọ ọ bụla. Ka gị na ọkọwa okwu kwuo okwu, kpọọ (800) 894-1374.

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Italian (Italiano): In caso di eventuali domande sul presente documento, ha il diritto di ricevere assistenza e informazioni nella sua lingua senza alcun costo aggiuntivo. Per parlare con un interprete, chiami il numero (800) 894-1374

Language Access Services:

Japanese (日本語): この文書についてなにかご不明な点があれば、あなたにはあなたの言語で無料で支援を受け情報を得る権利があります。通訳と話すには、(800) 894-1374 にお電話ください。

Khmer (ខ្មែរ): បើអ្នកមានសំណួរផ្សេងទៀតអំពីឯកសារនេះ អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មានជាភាសារបស់អ្នកដោយឥតគិតថ្លៃ។
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Ata' halne'ígíí ła' bich'i' hadeesdizih nínizingo koǫ́' hodiilnih (800) 894-1374.

Nepali (नेपाली): यदि यो कागजातबारे तपाईंसँग केही प्रश्नहरू छन् भने, आफ्नै भाषामा निःशुल्क सहयोग तथा जानकारी प्राप्त गर्न पाउने हक तपाईंसँग छ।
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Language Access Services:

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Language Access Services:

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