



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:

<http://www.fhcp.com/documents/coc/qhp-small-group-2026.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.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-877-615-4022 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | <a href="#">Network providers</a> : \$0.<br><a href="#">Out-of-network providers</a> : Not Covered                                                                                      | See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Not Applicable                                                                                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| Are there other <a href="#">deductibles</a> for specific services?              | Yes, \$3,500 individual / \$7,000 family for brand and specialty prescription drug coverage.                                                                                            | 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 services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | <a href="#">Network providers</a> : \$9,200 individual / \$18,400 family;<br><a href="#">Out-of-network providers</a> : Not Covered                                                     | 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. See <a href="https://www.fhcp.com/our-provider-network/">https://www.fhcp.com/our-provider-network/</a> or call 1 (877) 615-4022 for a list of <a href="#">network providers</a> . | 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 <a href="#">plan's 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 <a href="#">provider's</a> 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> ?    | Yes.                                                                                                                                                                                    | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</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                                                                                                                                                                                                                                                                                     |
|------------------------------------------------------------------------|--------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                        |                                                        | Network Provider<br>(You will pay the least)                                                                                                                                                                                                                                                                                                                                               | Out-of-Network Provider<br>(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       | \$30 <a href="#">Copay</a>                                                                                                                                                                                                                                                                                                                                                                 | Not Covered                                        | Additional cost share may apply for Allergy Shots, Injections and Infusions. See schedule of benefits for telehealth benefit specific cost sharing through designated <a href="#">provider</a> .                                                                                                                                           |
|                                                                        | <a href="#">Specialist</a> visit                       | \$50 <a href="#">Copay</a>                                                                                                                                                                                                                                                                                                                                                                 | Not Covered                                        | Additional cost share may apply for Allergy Shots, Injections and Infusions.                                                                                                                                                                                                                                                               |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No Charge                                                                                                                                                                                                                                                                                                                                                                                  | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed 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)    | \$20 <a href="#">Copay</a> for laboratory & professional services at an independent clinical lab.<br><br>\$40 <a href="#">Copay</a> for x-ray & diagnostic imaging at an independent diagnostic testing center.<br><br>\$40 <a href="#">Copay</a> for laboratory & professional services and \$80 <a href="#">Copay</a> for x-ray & diagnostic imaging at an outpatient hospital facility. | Not Covered                                        | Prior authorization is required.<br><br>Tests in hospitals, or facilities owned or operated by hospitals are subject to the outpatient hospital facility cost share.<br><br>Failure to obtain prior authorization for any service that requires prior authorization will result in a denial of benefits. See your policy for more details. |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | \$200 <a href="#">Copay</a> at an independent facility / \$400 <a href="#">Copay</a> at an outpatient hospital facility.                                                                                                                                                                                                                                                                   | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                            |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <http://www.fhcp.com/documents/coc/ghp-small-group-2026.pdf>.

| Common Medical Event                                                                                                                                                                                                                                                                                                                                            | Services You May Need                                                               | What You Will Pay                                                                                                           |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                                                                                                                                                                 |                                                                                     | Network Provider<br>(You will pay the least)                                                                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                               |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://fm.formularynavigator.com/FBO/126/2026_QHP_Formulary.pdf">prescription drug coverage</a> is available at <a href="https://fm.formularynavigator.com/FBO/126/2026_QHP_Formulary.pdf">https://fm.formularynavigator.com/FBO/126/2026_QHP_Formulary.pdf</a> | Generic drugs – preferred / non-preferred                                           | \$4 <a href="#">Copay</a> / \$35 <a href="#">Copay</a>                                                                      | Not Covered                                        | 31 Days per Benefit Period. Available at Preferred-FHCP and select Non-Preferred Retail Pharmacies Only. Up to 93-day Mail Order available through FHCP Only. Refer to the schedule of benefits for cost sharing at Non-Preferred Pharmacies. |
|                                                                                                                                                                                                                                                                                                                                                                 | Preferred brand drugs                                                               | <a href="#">Deductible</a> + 35% <a href="#">Coinsurance</a>                                                                | Not Covered                                        |                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 | Non-preferred brand drugs                                                           | <a href="#">Deductible</a> + 40% <a href="#">Coinsurance</a>                                                                | Not Covered                                        |                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Specialty drugs</a> – preferred / non-preferred                         | <a href="#">Deductible</a> + 45% <a href="#">Coinsurance</a> / <a href="#">Deductible</a> + 45% <a href="#">Coinsurance</a> | Not Covered                                        | 31 Days per Benefit Period. Available at FHCP Pharmacy Only. Mail Order not available.                                                                                                                                                        |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                                                                                                                                                           | Facility fee (ambulatory surgery center (ASC) / outpatient hospital facility (OHF)) | \$1,000 <a href="#">Copay</a> – ASC / \$1,500 <a href="#">Copay</a> – OHF                                                   | Not Covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency outpatient surgical care. Your benefits/services may be denied.                                                                                                    |
|                                                                                                                                                                                                                                                                                                                                                                 | Physician/surgeon fees                                                              | \$50 <a href="#">Copay</a>                                                                                                  | Not Covered                                        | Prior approval required. Your benefits/services may be denied.                                                                                                                                                                                |
| <b>If you need immediate medical attention</b>                                                                                                                                                                                                                                                                                                                  | <a href="#">Emergency room care</a>                                                 | \$300 <a href="#">Copay</a>                                                                                                 | \$300 <a href="#">Copay</a>                        | Waived if admitted.                                                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Emergency medical transportation</a>                                    | \$300 <a href="#">Copay</a>                                                                                                 | \$300 <a href="#">Copay</a>                        | None                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                                                                                                                                                                 | <a href="#">Urgent care</a>                                                         | \$75 <a href="#">Copay</a>                                                                                                  | \$75 <a href="#">Copay</a>                         | None                                                                                                                                                                                                                                          |
| <b>If you have a hospital stay</b>                                                                                                                                                                                                                                                                                                                              | Facility fee (e.g., hospital room)                                                  | \$2,000 <a href="#">Copay</a> per Day / \$8,000 maximum                                                                     | Not Covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.                                                                                                                  |
|                                                                                                                                                                                                                                                                                                                                                                 | Physician/surgeon fees                                                              | No Charge                                                                                                                   | Not Covered                                        | None                                                                                                                                                                                                                                          |
| <b>If you need mental health, behavioral health, or substance abuse services</b>                                                                                                                                                                                                                                                                                | Outpatient services                                                                 | \$50 <a href="#">Copay</a>                                                                                                  | Not Covered                                        | The cost share displayed applies to outpatient office visits only, other outpatient services may be subject to additional cost share.                                                                                                         |
|                                                                                                                                                                                                                                                                                                                                                                 | Inpatient services                                                                  | \$2,000 <a href="#">Copay</a> per Day / \$8,000 maximum                                                                     | Not Covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied.                                                                                                                  |
| <b>If you are pregnant</b>                                                                                                                                                                                                                                                                                                                                      | Office visits                                                                       | \$50 <a href="#">Copay</a>                                                                                                  | Not Covered                                        | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).                                                                                                                                              |

| Common Medical Event                                                  | Services You May Need                     | What You Will Pay                                       |                                                    | Limitations, Exceptions, & Other Important Information                                                                       |
|-----------------------------------------------------------------------|-------------------------------------------|---------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|
|                                                                       |                                           | Network Provider<br>(You will pay the least)            | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                              |
|                                                                       | Childbirth/delivery professional services | No Charge                                               | Not Covered                                        | Pre-certification/pre-authorization of coverage required for non-emergency admissions. Your benefits/services may be denied. |
|                                                                       | Childbirth/delivery facility services     | \$2,000 <a href="#">Copay</a> per Day / \$8,000 maximum | Not Covered                                        |                                                                                                                              |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | 45% <a href="#">Coinsurance</a>                         | Not Covered                                        | 20 Days per Benefit Period. Prior authorization is required.                                                                 |
|                                                                       | <a href="#">Rehabilitation services</a>   | \$50 <a href="#">Copay</a>                              | Not Covered                                        | 35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.                         |
|                                                                       | <a href="#">Habilitation services</a>     | \$50 <a href="#">Copay</a>                              | Not Covered                                        | 35 Visit(s) per Benefit Period. Includes physical therapy, speech therapy, and occupational therapy.                         |
|                                                                       | <a href="#">Skilled nursing care</a>      | \$50 <a href="#">Copay</a> per Day                      | Not Covered                                        | 60 Days per Benefit Period. Prior authorization is required.                                                                 |
|                                                                       | <a href="#">Durable medical equipment</a> | 45% <a href="#">Coinsurance</a>                         | Not Covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required.       |
|                                                                       | <a href="#">Hospice services</a>          | 45% <a href="#">Coinsurance</a>                         | Not Covered                                        | None                                                                                                                         |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam                       | \$10 <a href="#">Copay</a>                              | Not Covered                                        | Coverage limited to one exam/year.                                                                                           |
|                                                                       | Children's glasses                        | \$25 <a href="#">Copay</a>                              | Not Covered                                        | Coverage limited to one pair of glasses/year.                                                                                |
|                                                                       | Children's dental check-up                | No Charge                                               | Not Covered                                        | Coverage limited to two visits/year.                                                                                         |

#### 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> .)        |                                                                                                                       |                                                                                                                                                                                                 |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Abortion with the Exception of Limited Services</li> <li>Acupuncture</li> <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>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> <li>Routine foot care</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                             |                                                                                                                       |                                                                                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>                                                                                                                                      | <ul style="list-style-type: none"> <li>Weight loss programs</li> </ul>                                                |                                                                                                                                                                                                 |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <http://www.fhcp.com/documents/coc/ghp-small-group-2026.pdf>.

**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: State Department of Insurance at 1-877-693-5236, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa> or 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). 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 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: the insurer at 1-877-615-4022. You may also contact your State Department of Insurance at 1-877-693-5236 or the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

**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 1-877-615-4022

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-615-4022

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-615-4022

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-615-4022

*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> | \$0    |
| ■ <a href="#">Specialist copayment</a>                          | \$50   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$2000 |
| ■ Other <a href="#">copayment</a>                               | \$40   |

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:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$0     |
| <a href="#">Copayments</a>  | \$4,500 |
| <a href="#">Coinsurance</a> | \$0     |

| <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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$0    |
| ■ <a href="#">Specialist copayment</a>                          | \$50   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$2000 |
| ■ Other <a href="#">coinsurance</a>                             | 45%    |

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:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$3,100 |
| <a href="#">Copayments</a>  | \$900   |
| <a href="#">Coinsurance</a> | \$0     |

| <i>What isn't covered</i> |      |
|---------------------------|------|
| Limits or exclusions      | \$20 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$4,020</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> | \$0    |
| ■ <a href="#">Specialist copayment</a>                          | \$50   |
| ■ Hospital (facility) <a href="#">copayment</a>                 | \$2000 |
| ■ Other <a href="#">copayment</a>                               | \$300  |

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:

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$0     |
| <a href="#">Copayments</a>  | \$1,200 |
| <a href="#">Coinsurance</a> | \$100   |

| <i>What isn't covered</i> |     |
|---------------------------|-----|
| Limits or exclusions      | \$0 |

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$1,300</b> |
|-----------------------------------|----------------|

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