Summary of Benefits and Coverage: What this <u>Plan</u> Covers & What You Pay for Covered Services Coverage Period: 01/01/2025-12/31/2025

NAU HSA – Active

BlueCross BlueShield Arizona Coverage for: Individual & Family | Plan Type: HSA-qualified PPO

An Independent Licensee of the Blue Cross Blue Shield Association

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 azblue.com/member. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-800-423-6484 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Coverage for Individual Only:  In-network: \$1,650/individual Out-of-network: \$3,300/individual  Coverage for Family: In-network: \$3,300/family Out-of-network: \$6,600/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. Unless a <u>copay</u> , fee, or other percent is shown, the <u>coinsurance</u> percent of the <u>allowed amount</u> that you pay for most services is 10% <u>in-network</u> and 50% <u>out-of-network</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>in-network</u> <u>preventive</u> services.	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> .
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</u> <u>limit</u> for this <u>plan</u> ?	Coverage for Individual Only: In-network: \$2,000/individual Out-of-network: \$5,000/individual  Coverage for Family: In-network: \$4,000/family Out-of-network: \$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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the out-of-pocket limit?	Premiums, out-of-network prior authorization charges, balance bills, and costs for health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.azblue.com or call 1-800-423-6484 for a list of in-network providers.	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 <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

		What Yo	u Will Pay	Limitations, Exceptions, & Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information	
	Primary care visit to treat an injury or illness	10% coinsurance	50% coinsurance &	Claim may be denied or \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services. Medical	
	Campus Health Services	No charge after deductible	balance bill	telehealth consultations through BlueCare Anywhere <sup>SM</sup> .	
If you visit a health	Specialist visit	10% coinsurance		Anywhere	
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> & <u>balance bill</u>	Preventive services not required to be covered by state or federal law are not covered. You may have to pay for services that aren't preventive.  Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance & balance bill may apply	Claim may be denied or \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services.	

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\* For more information about limitations, exceptions and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

		What Yo	ou Will Pay	Limitations Evacutions 9 Other
<b>Common Medical Event</b>	Services You May Need	Network Provider	Out-of-Network Provider	Limitations, Exceptions, & Other Important Information
		(You will pay the least)	(You will pay the most)	· ·
		\$10 copay/30 day supply,	\$10 copay/30 day supply &	Some drugs require <u>prior authorization</u> and won't
	Tier 1	copay applies after deductible	<u>balance bill</u> , <u>copay</u> applies after deductible	be covered without it. 90-day supply costs 2.5 copays for retail pharmacy. Mail order not covered
				out-of-network.
	Tier 2	\$25 <u>copay</u> /30 day supply, <u>copay</u> applies after	\$25 <u>copay</u> /30 day supply & <u>balance bill, copay</u> applies	out of notwork.
	IICI Z	deductible	after <u>deductible</u>	Mail order in-network copay (copay applies after
If you need drugs to		\$45 copay/30 day supply,	\$45 copay/30 day supply &	deductible): Tier 1: \$10
treat your illness or	Tier 3	copay applies after	balance bill, copay applies	Tier 2: \$25
condition		<u>deductible</u>	after <u>deductible</u>	Tier 3: \$135
More information about		\$85 <u>copay</u> /30 day supply,	\$85 copay/30 day supply &	Tier 4: \$255
prescription drug coverage is available at	Tier 4	copay applies after	balance bill, copay applies after deductible	
www.azblue.com		deductible		Members will not have access to Target or CVS
		Copays (apply after		pharmacies.
		deductible):		
	Specialty drugs	Tier A: \$30	Not covered	Specialty <u>copay</u> covers up to a 30-day supply. No coverage without <u>prior</u> <u>authorization</u> .
		Tier B: \$60		
		Tier C: \$90		
	Facility fee (e.g.,	Tier D: \$120		
If you have outpatient	ambulatory surgery center)		50% coinsurance & balance	Claim may be denied or \$300 charge if no <u>prior</u>
surgery	, , ,	10% coinsurance	bill may apply	authorization for out-of-network services.
	Physician/surgeon fees		_ , ,,,,	
	_	1001		Out-of-network providers can't balance bill for the
If you need immediate medical attention	Emergency room care	10% coinsurance		difference between the <u>allowed amount</u> and the billed charge.
	Emergency medical			
	transportation	10% coinsurance		None
	Urgent care	10% coinsurance	50% coinsurance & balance	None
	<u>organic dara</u>	1070 Somodianios	<u>bill</u>	

Page 3 of 10 \* For more information about limitations, exceptions and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

			u Will Pay	Limitations, Exceptions, & Other
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Important Information
	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance & balance	Claim may be denied or \$300 charge if no <u>prior</u> authorization for out-of-network services.
If you have a hospital	Physician/surgeon fees		biii may appry	dutionzation for out of network services.
stay	Long-term acute care	10% <u>coinsurance</u>	50% <u>coinsurance</u> & <u>balance</u> <u>bill</u> may apply	Claim may be denied or \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services. Limit of 365 total LTAC days per member.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after <u>deductible</u>	50% coinsurance & balance bill may apply	Claim may be denied or \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services.  Counseling telehealth consultations and Psychiatric telehealth consultations are covered through BlueCare Anywhere <sup>SM</sup> .
abuse services	Inpatient services	10% coinsurance	50% coinsurance & balance bill may apply	Claim may be denied or \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services.
	Office Visits		50% coinsurance & balance bill may apply	Materials and many include tests and coming
If you are pregnant	Childbirth/delivery professional services	10% coinsurance		Maternity care may include tests and services described elsewhere in the <u>SBC</u> (i.e. ultrasound). <u>Cost sharing</u> does not apply for <u>in-network</u>
	Childbirth/delivery facility services		<u>σιιι</u> παγ αρριγ	preventive services.

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		What You Will Pay		Limitations Evacutions 9 Other	
Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
If you need help recovering or have other special health needs	Home health care/Home infusion therapy	10% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services. Limit of 42 visits (of up to 4 hours)/calendar year. Custodial care excluded	
	Rehabilitation services  • EAR = Extended Active Rehabilitation Facility  • PT/ST/OT = Physical Therapy, Occupational Therapy, Speech Therapy	EAR: 10% coinsurance PT/OT: 10% coinsurance for the first 160 modalities or therapeutic services or 20 visits for ST, then 50% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u> may apply	Claim may be denied \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services.  Limit of 120 days/calendar year for EAR and 180	
	Habilitation services	Not covered	Not covered	days/calendar year for SNF. Plan does not cover	
	Skilled nursing care In skilled nursing facility (SNF)	10% coinsurance	50% coinsurance & balance bill may apply	group physical and occupational therapy.	
	Durable medical equipment	10% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services. Limit of 1 hearing aid per member per ear every 3 calendar years.	
	Hospice services	10% coinsurance	50% <u>coinsurance</u> & <u>balance bill</u>	Claim may be denied \$300 charge if no <u>prior</u> <u>authorization</u> for <u>out-of-network</u> services.	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Excluded. <u>Screening</u> for members under age 5 covered under " <u>Preventive care</u> / <u>screening</u> / immunization."	
	Children's glasses	Not covered	Not covered	Excluded	
	Children's dental check-up	Not covered	Not covered	Excluded	

Page 5 of 10 \* For more information about limitations, exceptions and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

### **Excluded Services & Other Covered Services:**

# Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Alternative medicine
- Care that is not medically necessary
- Cosmetic surgery, cosmetic services & supplies
- Custodial care
- Dental care except as stated in plan
- DME rental/repair charges that exceed DME purchase price
- Experimental and investigational treatments except as stated in plan
- Eyewear except as stated in plan
- Flat feet treatment and services

- Genetic and chromosomal testing, except as stated in plan
- Habilitation services
- Home health care and infusion therapy exceeding 42 visits (of up to 4 hours)/calendar year
- Inpatient EAR treatment exceeding 120 days per calendar year and inpatient SNF treatment exceeding 180 days per calendar year
- 365 days benefit plan maximum
- Massage therapy other than allowed under evidence-based criteria

- Out-of-network Mail Order drugs and out-of-network Specialty drugs
- Preventive services not required to be covered by state or federal law
- Private-duty nursing
- Respite care, except as stated in plan
- Routine eye care except as stated in the benefit plan
- Routine foot care
- Long-term care, except long-term acute care up to a Services, tests and procedures that are excluded under medical coverage guidelines
  - Weight loss programs

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

- Bariatric surgery
- Chiropractic care
- Fertility and infertility medication and treatment
- Hearing aids, limited to one hearing aid per member Non-emergency care when traveling outside the per ear every 3 calendar years
  - U.S.
  - Sexual dysfunction treatment and services

<sup>\*</sup> For more information about limitations, exceptions and prior authorization, see the plan or policy document at www.azblue.com/member.

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 group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or <a href="https://www.cciio.cms.gov">www.cciio.cms.gov</a>.
- Church <u>plans</u> are not covered by the Federal <u>COBRA</u> continuation coverage rules. If the coverage is insured, individuals should contact the Arizona Department of Insurance (602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area) regarding their possible rights to continuation coverage under State law.

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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact:

- For group health coverage subject to ERISA, contact Blue Cross Blue Shield of Arizona at 1-800-423-6484. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area.
- For non-federal governmental group health plans and church plans that are group health plans, contact Blue Cross Blue Shield of Arizona at 1-800-423-6484. If your coverage is insured, you may also contact the Arizona Department of Insurance at 602-364-2499, or 1-800-325-2548 in Arizona but outside the Phoenix area or <a href="https://difi.az.gov/consumer/i/health">https://difi.az.gov/consumer/i/health</a>.

# 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 <u>plan</u> 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.

<sup>\*</sup> For more information about limitations, exceptions and prior authorization, see the <u>plan</u> or policy document at <u>www.azblue.com/member</u>.

# **Multi-language Interpreter Services**

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nílínigíí Blue Cross Blue Shield of Arizona haada yit'éego bína'ídíłkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yína'ídíłkidgo beehaz'áanii hóló díí t'áá hazaadk'ehjí háká a'doowołgo bee haz'á doo bááh ílínígóó. Ata' halne'ígíí kojí' bich'j' hodíilnih 877-475-4799.

Chinese: 如果您,或是您正在協助的對象,有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題,您有權利免費以您的 母語得到幫助和訊息。洽詢一位翻譯員,請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

#### Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة للتحدث مع مترجم اتصل ب 4799-475-877.

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue Cross Blue Shield of Arizona, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 877-475-4799.

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue Cross Blue Shield of Arizona 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 877-475-4799 로 전화하십시오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue Cross Blue Shield of Arizona, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 877-475-4799.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue Cross Blue Shield of Arizona haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 877-475-4799 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue Cross Blue Shield of Arizona, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 877-475-4799.

Japanese: ご本人様、またはお客様の身の回りの方でも、Blue Cross Blue Shield of Arizona についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、877-475-4799 までお電話ください。

#### Farsi:

اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue Cross Blue Shield of Arizona ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 877-475-778 تماس حاصل نمایید.

#### Assvrian

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue Cross Blue Shield of Arizona, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 877-475-4799.

Thai: หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีค่าถามเกี่ยวกับ Blue Cross Blue Shield of Arizona คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 877-475-4799

# To see examples of how this <u>plan</u> might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## **About These Coverage Examples**

This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$1,650
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other <u>coinsurance</u>	10%

### This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	\$12,700

# In this example, Peg would pay:

Cost Sharing		
<u>Deductibles</u>	\$1,650	
<u>Copayments</u>	\$0	
Coinsurance	\$350	
What isn't covered		
Limits or exclusions	\$50	
The total Peg would pay is	\$2,050	

# **Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$1,650
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

## This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (*including disease education*)

Diagnostic tests (blood work)

Prescription drugs

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600
•	

# In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
Copayments	\$0
<u>Coinsurance</u>	\$350
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

# **Mia's Simple Fracture**

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$1,650
■ Specialist coinsurance	10%
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

## This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800

# In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
Copayments	\$0
Coinsurance	\$120
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,770

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

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