




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 www.ACBLBenefits.com or call 1-866-885-1033. 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 from ACBLBenefits@bargeacbl.com call 1-866-885-1033 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		Network	Non-Network	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 <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
	Per participant:	\$750	\$1,500	
	Per family:	\$1,500	\$3,000	
Are there services covered before you meet your deductible?	Yes. The following in-network services are covered before the in-network <u>deductible</u> is met: <u>preventive care</u> , emergency room facility services (in-network and non-network), <u>urgent care</u> services, well newborn baby care, outpatient therapy services, outpatient chemotherapy/radiation, chiropractic care, telemedicine services, outpatient mental health/substance use disorder services, and <u>prescription drugs</u> . Certain in-network services when performed in an office setting (advanced imaging, hearing exams, lab & x-rays, ostomy supplies) are also covered before the <u>deductible</u> is met.			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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.			You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	Medical Out-of-Pocket			The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
		Network	Non-Network	
	Per participant:	\$4,000	Unlimited	
Per family:	\$8,000	Unlimited		

	Prescription Drug Out-of-Pocket			
		Network		Non-Network
	Per participant:	\$4,000		Unlimited
	Per family:	\$8,000		Unlimited
What is not included in the <u>out-of-pocket limit</u>?	<p>Premiums, <u>balance-billed</u> charges, health care this <u>Plan</u> doesn't cover, charges in excess of benefit maximums, charges in excess of maximum allowed amounts, pre-certification penalties, and non-medically necessary services.</p> <p>Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the <u>out-of-pocket limits</u>. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied toward satisfying your <u>out-of-pocket limits</u>.</p>		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>?	<p>Yes, for medical: Anthem. See www.ACBLBenefits.com or call 1-866-885-1033 for a list of network providers.</p> <p>Yes, for prescription drugs: Express Scripts, Inc. For a list of retail and mail pharmacies, log on to www.express-scripts.com or call 1-866-885-1033.</p>		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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copayment, deductible waived	50% coinsurance	The office visit <u>co-payment</u> will apply to the office visit and all other office services, including lab and x-rays.
	<u>Specialist</u> visit	\$35 copayment, deductible waived	50% coinsurance	Home visits are covered.

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Preventive care/screening/immunization</u>	No Charge, deductible waived	50% coinsurance	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% coinsurance	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	20% co-insurance	50% coinsurance	Pre-certification is required for MRI/MRA and PET scans. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com	Generic drugs	Retail: \$10 copayment/rx, deductible waived Mail Order: \$25 copayment/rx, deductible waived	Not Covered	Retail: limited to a thirty-four (34) day supply. Mail Order: limited to a one hundred (100) day supply. Not all <u>prescription drugs</u> are covered. To determine if a specific drug is covered under your <u>plan</u> , log into your account at www.express-scripts.com .
	Preferred brand drugs	Retail: \$40 copayment/rx, deductible waived Mail Order: \$100 copayment/rx, deductible waived	Not Covered	If you obtain <u>prescription drugs</u> from a non-network pharmacy, you will be required to pay the full cost of the prescription.
	Non-preferred brand drugs	Retail: \$75 copayment/rx, deductible waived Mail Order: \$190 copayment/rx, deductible waived	Not Covered	For maintenance medications, the <u>Plan</u> only covers the cost of the original prescription plus two (2) retail pharmacy refills. Following the two (2) retail refills, plan participants must utilize mail order to obtain the medication.
	<u>Specialty drugs</u>	**Retail: 20% coinsurance, deductible waived up to	Not Covered	Some drugs may require prior authorization. If not obtained, the drug may not be covered. **Specialty drugs are only covered when obtained through Accredo Specialty Pharmacies. Call 1-800-803-2523 for further information. Please see "Important Questions" regarding

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
		\$150 **Mail Order: 20% coinsurance, deductible waived up to \$300		the Plan's out-of-pocket limit for additional information on Specialty drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 copayment/visit, deductible waived	50% coinsurance	Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan. _____none_____
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	\$250 copayment/visit, deductible waived		The <u>emergency room care co-payment</u> will apply to the <u>emergency room care</u> visit and all other services, including lab and x-rays. <u>Copayment</u> is waived if the plan participant is admitted to an inpatient stay.
	<u>Emergency medical transportation</u>	20% coinsurance		<u>Network deductible</u> applies to non- <u>network</u> services.
	<u>Urgent care</u>	\$35 copayment, deductible waived	50% coinsurance	The <u>urgent care co-payment</u> will apply to the <u>urgent care</u> visit and all other services, including lab and x-rays. Retail clinics are covered.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan. _____none_____
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	\$10 copayment/visit, deductible waived	50% coinsurance	Pre-certification is required for intensive outpatient services and partial hospitalization services. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	Inpatient services	20% coinsurance	50% coinsurance	Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
If you are pregnant	Office visits	First Visit Only: \$35 copayment, deductible waived All Other Visits: 20% co-insurance	50% coinsurance	Routine pre-natal care is covered at no charge after initial visit. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-certification is required for inpatient stays longer than forty-eight (48) hours for vaginal delivery or ninety-six (96) hours for cesarean delivery. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	
If you need help recovering or have other special needs	<u>Home health care</u>	20% coinsurance	50% coinsurance	Calendar Year Maximum: one hundred and twenty (120) visits. Home infusion services do not apply to the <u>home health care</u> calendar year maximum. Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	<u>Rehabilitation services</u>	Inpatient Rehabilitation Services: 20% coinsurance Outpatient: \$35 copayment/visit, deductible waived	50% coinsurance	<p>Calendar Year Maximum: thirty-six (36) visits for occupational therapy, thirty-six (36) visits for speech therapy, thirty-six (36) visits for cardiac rehabilitation, and thirty-six (36) visits for pulmonary rehabilitation.</p> <p><u>Inpatient rehabilitation services</u> apply to the <u>skilled nursing care</u> calendar year maximum.</p> <p>Therapy provided in the home when not rendered as part of a <u>home health care</u> plan applies to above maximums.</p> <p>Calendar Year Maximum: one hundred and twenty (120) days combined with inpatient rehabilitation facilities.</p> <p>Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.</p> <p>Repair/replacement are covered.</p> <p>Pre-certification is required for all rentals and any purchase over \$1,500. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.</p> <p>Lifetime Maximum: three hundred and sixty-five (365) days.</p> <p>Pre-certification is required. Failure to obtain pre-certification may result in a \$500 reduction in benefits paid by the Plan.</p>
	<u>Habilitation services</u>			
	<u>Skilled nursing care</u>	20% coinsurance	50% coinsurance	
	<u>Durable medical equipment</u>	20% coinsurance	50% coinsurance	
	<u>Hospice services</u>	20% coinsurance	50% coinsurance	
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	

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

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
- Cosmetic Surgery (except for newborn children or when due to trauma or disease)
- Dental Care (Adult)
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care When Traveling Outside the U.S. (except Global Core)
- Private-Duty Nursing
- Routine Eye Care
- Routine Foot Care (except for plan participants with diabetes)
- 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 (limited to a diagnosis of morbid obesity)
- Chiropractic Care [limited to twelve (12) visits per calendar year]
- Hearing Aids (limited to \$5,000 for all hearing services per calendar year)

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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan's COBRA Administrator, Wex Health, at 1-866-451-3399. 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Care Coordinators for further information. The Care Coordinator's name, address, and telephone number are:

Quantum Health Care Coordinators
5240 Blazer Way
Dublin OH 43017
1-866-885-1033

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 1-866-885-1033.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-885-1033.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-885-1033.

* For more information about limitations and exceptions, see the plan or policy document at www.ACBLBenefits.com.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-885-1033.

To see examples of how this [plan](#) 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.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.ACBLBenefits.com.

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 \$750
- Specialist copayment \$35
- Hospital (facility) cost sharing 20%
- Other cost sharing 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	\$12,700
---------------------------	-----------------

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$2,300
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$3,080

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

- The plan's overall deductible \$750
- Specialist copayment \$35
- Hospital (facility) cost sharing 20%
- Other cost sharing 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	\$5,600
---------------------------	----------------

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$890

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

- The plan's overall deductible \$750
- Specialist copayment \$35
- Hospital (facility) cost sharing 20%
- Other cost sharing 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	\$2,800
---------------------------	----------------

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$500
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,340

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

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish

Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese

您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese

Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean

귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog

May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian

У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole

Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòm nan dokiman sa a.

Arabic

لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French

Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian

شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian

Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցող էք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese

あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会

員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian

Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German

Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer ID-Karte an. Sehbehindert? Sie können dieses Dokument auch in anderen Formaten anfordern.

Polish

Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch

Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei ID Card. Hoscht Druwwel fer sehne? Du kantscht des do Schreiwes in en differnter Weg griege so as du's besser sehne kantscht.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications—as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose

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

primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator, P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

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