

Walmart Inc.: Saver Plan for Dallas/Fort Worth work locationsCoverage for: Associate Only; Associate + Spouse/Partner, Associate + Children, and Associate + Family | Plan Type: PPO

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, contact the claims administrator at 1-800-421-1362 or visit [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits). 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 <https://www.healthcare.gov/sbc-glossary> or call 1-800-421-1362 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	<u>Network</u> : \$3,000 individual/ \$6,000 family; <u>Out-of-Network</u> : Services are not covered. Charges for <u>balance billing</u> , healthcare this <u>plan</u> does not cover, services at out-of-network Walmart Care Clinic or Walmart Health, amounts from third parties to assist with <u>prescription drug</u> purchases, <u>copayments</u> for certain preventive medications not subject to the annual <u>deductible</u> , and amounts the <u>plan</u> pays at 100% do not count toward the <u>deductible</u> .	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> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. The employer contribution to the HSA is \$350/Associate or \$700/Family, which may be used for qualified medical expenses. If you had an HRA balance and moved into this <u>plan</u> , any HRA balance is immediately forfeited.
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Deductible</u> is waived for certain <u>preventive care</u> and Doctor On Demand (through 2021).	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<u>Network</u> : \$6,650 individual/ \$13,300 family <u>Out-of-Network</u> : Services are not covered	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, penalties for failure to obtain <u>preauthorization</u> for services, health care this <u>plan</u> doesn't cover, <u>out-of-network</u> <u>coinsurance</u> , services at out-of-network Walmart Care Clinic or Walmart Health, amounts from third parties to assist with <u>prescription drug</u> purchases and amounts the <u>plan</u> pays at 100%.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

\* For more detail about limitations and exceptions, see Summary Plan Description and Summary of Material Modifications (SPD) at [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits).

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.One.Walmart.com/ProviderGuide">www.One.Walmart.com/ProviderGuide</a> or call 1-866-823-3790 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay the least if you use a Preferred <u>Provider</u> in the <u>plan's network</u> . You will pay more if you use a Nonpreferred <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, unless otherwise noted.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You pay the least for Preferred Providers)	<u>Out-of-Network Provider</u> (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	<i>Preferred:</i> 25% <u>coinsurance</u> ; <i>Nonpreferred:</i> 50% <u>coinsurance</u>	Not covered	If no Preferred <u>Provider</u> is available, <u>in-network</u> covered services will be paid at the Preferred <u>Provider</u> rate. *See the "Medical Plan" section of SPD. Special rules, including lower <u>copayments</u> , after your <u>deductible</u> is met, may apply to services received from an <u>in-network</u> Walmart Care Clinic or Walmart Health. *See the "Walmart Care Clinic and Walmart Health" section of the SPD. Doctor On Demand visits have a \$4 <u>copayment</u> after your <u>deductible</u> is met. However, the \$4 <u>copayment</u> is waived during the COVID-19 national emergency, and through 2021, the <u>deductible</u> does not apply to Doctor On Demand visits. <u>Preauthorization</u> may be required. *See the " <u>Preauthorization</u> " section in the SPD. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. *See the " <u>Preventive care</u> program" section in the SPD for covered <u>preventive services</u> and applicable limitations. During COVID-19 public health emergency, there is no charge for a COVID-19 test or <u>diagnostic tests</u> that result in COVID-19 testing at an <u>in-network</u> or an <u>out-of-network provider</u> .
	<u>Specialist</u> visit	<i>Preferred:</i> 25% <u>coinsurance</u> ; <i>Nonpreferred:</i> 50% <u>coinsurance</u>	Not covered	
	<u>Preventive care</u> / <u>screening</u> / <u>immunization</u>	<i>Preferred:</i> No charge; <i>Nonpreferred:</i> 50% <u>coinsurance</u> , <u>deductible</u> doesn't apply	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	Not covered	During the COVID-19 public health emergency, there is no charge for a COVID-19 test or <u>diagnostic tests</u> that result in COVID-19 testing at an <u>in-network</u> or an <u>out-of-network provider</u> .

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information	
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)		
	Imaging (CT/PET scans, MRIs)	50% <u>coinsurance</u> ; 25% <u>coinsurance</u> for alternate <u>network provider</u>	Not covered	<u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. PET scans are reimbursed as a <u>diagnostic test</u> . *See “Alternate provider networks” section in the SPD.	
<b>If you need drugs to treat your illness or condition</b>  More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.OptumRx.com/Walmart">www.OptumRx.com/Walmart</a>	Generic drugs	\$4 <u>copayment</u> (1-30 days); \$8 <u>copayment</u> (31-60 days); \$12 <u>copayment</u> (61-90 days)	Not covered	You pay full price up to your annual <u>deductible</u> , then the <u>copayment</u> rules apply. If you work within 5 miles of a Walmart or Sam’s Club pharmacy, only drugs purchased at Walmart or Sam’s Club are covered, unless an exception applies. If you work more than 5 miles from a Walmart or Sam’s Club pharmacy, a 30-day supply of generic drugs purchased at a pharmacy in the OptumRx <u>network</u> will be covered at the same rate. If you work more than 5 miles from a Walmart or Sam’s Club pharmacy, generic drugs exceeding a 30-day supply must be purchased at a Walmart or Sam’s Club pharmacy or through mail-order. *See “The Pharmacy Benefit” section in the SPD for exceptions. Mail-order <u>prescription drugs</u> will be covered only when purchased through Walmart/Sam’s Club or OptumRx mail-order pharmacy regardless of work location. High-cost generic drugs are not covered when a therapeutically equivalent, lower-cost generic drugs are available. Supplies of preferred brand drugs of more than 30 days must be purchased by mail-order.	
	Preferred brand drugs	Greater of \$50 or 25% <u>coinsurance</u> , <u>deductible</u> doesn’t apply (30 days)	Not covered		
	Non-preferred brand drugs	Not covered	Not covered		Non-Preferred brand drugs are not covered.
	<u>Specialty drugs</u>	Greater of \$50 or 20% <u>coinsurance</u> , <u>deductible</u> doesn’t apply (30 days)	Not covered		<u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. <u>Specialty drugs</u> are only available at a Walmart Specialty or OptumRx Specialty pharmacy. Prescriptions for <u>specialty drugs</u> are not covered when purchased at a non- <u>network</u> pharmacy.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See “ <u>Preauthorization</u> ” section in SPD.	
	Physician/ surgeon fees	<i>Preferred:</i> 25% <u>coinsurance</u> <i>Nonpreferred:</i> 50% <u>coinsurance</u>	Not covered	If no Preferred <u>Provider</u> is available, in- <u>network</u> covered services will be paid at the Preferred <u>Provider</u> rate. <u>Preauthorization</u> may be required. *See “ <u>Preauthorization</u> ” section in SPD.	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$300 <u>copayment</u> , in addition to any remaining <u>deductible</u>	\$300 <u>copayment</u> , in addition to any remaining <u>deductible</u> and  0% <u>coinsurance</u> for <u>emergency services</u> ; or 50% <u>coinsurance</u> for non- <u>emergency services</u> ;	If you are admitted to the hospital directly from the emergency room, the <u>copayment</u> is waived.
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	25% <u>coinsurance</u> for <u>emergency services</u> ; no coverage for non-emergency services	Coverage is limited to the nearest hospital or treatment facility capable of providing care, and only if such transportation is <u>medically necessary</u> as compared to other transportation methods of lower cost and safety. Non-emergency transport is not covered, except if pre-authorized.
	<u>Urgent care</u>	<i>Preferred: 25% <u>coinsurance</u> Nonpreferred: 50% <u>coinsurance</u></i>	Not covered	If no Preferred <u>Provider</u> is available, in- <u>network</u> covered services will be paid at the Preferred <u>Provider</u> rate
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	Not covered	If no Preferred <u>Provider</u> is available, in- <u>network</u> covered services will be paid at the Preferred <u>Provider</u> rate. <u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in SPD. For heart surgery, dialysis/ ESRD medical record review, spine, hip or knee replacement evaluation or surgery; breast, lung, blood, prostate, and colorectal cancer review; and organ and tissue transplants, coverage is 100% (after <u>deductible</u> ), through the Centers of Excellence (COE) Program. When not performed through the COE Program, spine and weight loss surgeries and organ and tissue transplants are not covered, even if performed by a <u>network provider</u> , unless an exception applies. When not performed through the COE Program, a hip or knee replacement is subject to the <u>deductible</u> and there is a 50% <u>coinsurance</u> , even if performed by a <u>network provider</u> , unless an exception applies. *See the “Centers of Excellence” section in SPD.
	Physician/ surgeon fees	<i>Preferred: 25% <u>coinsurance</u> Nonpreferred: 50% <u>coinsurance</u></i>	Not covered	
If you need mental health, behavioral	Outpatient services	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. Doctor On Demand visits have a \$4 <u>copayment</u> after your <u>deductible</u> is

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
health, or substance abuse services	Inpatient services	25% <u>coinsurance</u>	Not covered	met. However, the \$4 <u>copayment</u> is waived during the COVID-19 national emergency, and through 2021, the <u>deductible</u> does not apply to Doctor On Demand visits.
If you are pregnant	Office visits	<u>Preventive Care:</u> <i>Preferred:</i> No charge; <i>Nonpreferred:</i> 50% <u>coinsurance</u> , <u>deductible</u> doesn't apply  All other services: <i>Preferred:</i> 25% <u>coinsurance</u> <i>Nonpreferred:</i> 50% <u>coinsurance</u>	Not covered	If no Preferred <u>Provider</u> is available, in- <u>network</u> covered services will be paid at the Preferred <u>Provider</u> rate. *See the "Medical <u>Plan</u> " section of SPD. <u>Cost sharing</u> does not apply for <u>preventive services</u> . You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. <u>Preauthorization</u> may be required for stays exceeding standard length of stay for maternity.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See the " <u>Preauthorization</u> " section in the SPD. <u>Home health care</u> is limited to 100 visits per calendar year. Other limitations may apply. *See the "When limited benefits apply to the Associates' Medical <u>Plan</u> " section in the SPD.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See the " <u>Preauthorization</u> " section in the SPD. See the "When Limited Benefits Apply to the Associates' Medical <u>Plan</u> " section of the SPD. <u>Rehabilitation services</u> are limited as follows: Physical therapy limited to 20 visits/year, Occupational therapy limited to 20 visits/year, Speech therapy limited to 60 visits/year, and Certain other inpatient <u>rehabilitation services</u> are limited to 120 days per condition.
	<u>Habilitation services</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See " <u>Preauthorization</u> " section in the SPD. <u>Habilitation services</u> are limited to Applied Behavior Analysis therapy.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You pay the least for Preferred Providers)	Out-of-Network Provider (You pay the most)	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. Skilled nursing facilities are limited to 60 days per /disability period. *See the “When Limited Benefits Apply to the Associates’ Medical <u>Plan</u> ” section in the SPD.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. Orthopedic shoes when prescribed by a physician are limited to one pair per calendar year.
	<u>Hospice services</u>	25% <u>coinsurance</u>	Not covered	<u>Preauthorization</u> may be required. *See the “ <u>Preauthorization</u> ” section in the SPD. <u>Hospice services</u> are limited to 365 days per illness.
<b>If your child needs dental or eye care</b>	Children’s eye exam	No charge, <u>deductible</u> doesn’t apply	Not covered	Limited to <u>screening</u> that qualifies as <u>preventive services</u> . *See the “ <u>Preventive Care Program</u> ” section in the SPD for covered <u>preventive services</u> and applicable limitations.
	Children’s glasses	Not covered	Not covered	Glasses are limited when a certain medical diagnosis applies or from eye injury. See the “When Limited Benefits Apply to the Associates’ Medical <u>Plan</u> ” section in the SPD.
	Children’s dental check-up	Not covered	Not covered	Dental check-ups are not covered under medical benefits; however, there may be additional other coverage under a separate dental <u>plan</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       | • Glasses                   | • Routine eye care     |
| • Chiropractic care | • Hearing aids              | • Weight loss programs |
| • Dental care       | • Non-preferred brand drugs |                        |

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

- |  |  |  |
|--|--|--|
| • Bariatric surgery (gastric bypass and gastric sleeve surgery only)                           | • Non-Emergency Care when traveling Outside the U.S. (as provided by international business medical insurance policy)                                    | • Routine eye care (limited to services and limitations that are identified under the “ <u>Preventive Care</u> ” section of the SPD) |
| • Cosmetic Surgery (limited to conditions that are considered reconstructive)                  | • Private-duty nursing (limited to 100 visits per calendar, billed through a home health agency, and must be provided by a licensed or registered nurse) | • Routine foot care (nonsurgical foot care limited to 3 visits per calendar year)  |
| • Infertility treatment (limited to the diagnosis & treatment of underlying medical condition. |  |  |
| • Long-term care – Up to 60 days/disability period   |  |  |

\* For more detail about limitations and exceptions, see Summary Plan Description and Summary of Material Modifications (SPD) at [www.One.Walmart.com/Benefits](http://www.One.Walmart.com/Benefits).

**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](http://www.dol.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace visit [www.HealthCare.gov](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: Walmart People Services, Attn: Internal Appeals, 508 SW 8<sup>th</sup> Street, Bentonville, AR 72716-3500. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) and <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

**Does this plan provide Minimum Essential Coverage? Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

**Does this plan meet the Minimum Value Standards? Yes.**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-421-1362.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-421-1362.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-421-1362.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-421-1362.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

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**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 \$3,000
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

**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>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$10
Coinsurance	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,470</b>

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

- The plan's overall deductible \$3,000
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

**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>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$100
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,820</b>

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

- The plan's overall deductible \$3,000
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

**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>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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

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