This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the plan document at https://benefits.cooperative.com or by calling **1-866-673-2299**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$50** Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out–of–pocket limit** on your expenses.
Is there an overall annual limit on what the plan pays?	Yes, **$2000**	The chart on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	No.	This plan treats **providers** the same in determining payment for the same services.
Do I need a referral to see a specialist?	No. You do not need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- Your cost sharing does not depend on whether a provider is in a network.

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered.	No coverage for these services.
	Specialist visit	Not covered.	
	Other practitioner office visit	Not covered.	
	Preventive care/screening/immunization	Not covered.	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered.	No coverage for these services.
	Imaging (CT/PET scans, MRIs)	Not covered.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.[insert].	Generic drugs	Not covered.	No coverage for these services.
	Preferred brand drugs	Not covered.	
	Non-preferred brand drugs	Not covered.	
	Specialty drugs	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.	No coverage for these services.
	Physician/surgeon fees	Not covered.	
If you need	Emergency room services	Not covered.	No coverage for these services.

Common Medical Event	Services You May Need	Your cost	Limitations & Exceptions
immediate medical attention	Emergency medical transportation	Not covered.	
	Urgent care	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	No coverage for these services.
	Physician/surgeon fee	Not covered.	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Not covered.	No coverage for these services.
	Mental/Behavioral health inpatient services	Not covered.	
	Substance use disorder outpatient services	Not covered.	
	Substance use disorder inpatient services	Not covered.	
If you are pregnant	Prenatal and postnatal care	Not covered.	No coverage for these services.
	Delivery and all inpatient services	Not covered.	
If you need help recovering or have other special health needs	Home health care	Not covered.	No coverage for these services.
	Rehabilitation services	Not covered.	
	Habilitation services	Not covered.	
	Skilled nursing care	Not covered.	
	Durable medical equipment	Not covered.	
	Hospice service	Not covered.	
If your child needs dental or eye care	Eye exam	Not covered.	No coverage for these services.
	Glasses	Not covered.	No coverage for these services.
	Dental check-up	No charge.	Coverage is limited to 2 visits per person per calendar year.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Hearing aide
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Dental care
- Non-emergency care when traveling outside the U.S. See page 5 for more information.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-866-673-2299. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Cooperative Benefit Administrators, Inc. at 1-866-673-2299. 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.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does not provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-673-2299.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-673-2299.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-866-673-2299.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-673-2299.

Other Information:

Coverage is subject to reasonable and customary (R&C) rates in the area of service. The R&C rates are the current, most common fees charged in a geographic area for a particular treatment or service. These fees are researched by CBA and are reviewed on a regular basis.

Coverage While Traveling Outside the United States
In order for a service obtained outside the United States to be covered, the information provided to the plan must include the following: the service must be a recognized service in the United States; all provider billings and/or records must be translated into English; bills must clearly show the patient's name, provider's name, date of service, diagnosis and a description of the services rendered; and the current money exchange rate needs to be provided with the bill showing the daily rate for the dates the services were rendered. The participant will be required to pay for all services up front before submitting charges to the plan.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $0
- **Patient pays** $7,540

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays: This condition is not covered, so patient pays 100%.

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$7,540
Total	**$7,540**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $0
- **Patient pays** $5,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays: This condition is not covered, so patient pays 100%.

Deductibles	$0
Copays	$0
Coinsurance	$0
Limits or exclusions	$5,400
Total	**$5,400**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.