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?	**$1,500** person /**$3,000** family Doesn't apply to preventive services. For non-participating providers **$3,000** person/**$6,000** family.	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?	Yes. **$1,500** person/**$3,000** family. Yes. For non-participating **providers** **$3,000** person/**$6,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductible, difference in reasonable and customary (R&C) rates, charges incurred due to failure to obtain pre-certification, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	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?	Yes. See https://benefits.cooperative.com for a list of participating **providers**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.

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 6. 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**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.
	Specialist visit	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.
	Other practitioner office visit	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.
	Preventive care/screening/immunization	No charge.	30% coinsurance	Age and gender limitations apply. Coverage is subject to **UCR**.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**. **Preauthorization** is required for non-emergency, outpatient CT, MRI, MRA, PET, and nuclear cardiology scans*****see p.6.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://benefits.cooperative.com	Generic drugs	10% coinsurance	30% coinsurance	Retirees and dependents of retirees for whom Medicare is the primary insurer, see page 7.
	Preferred brand drugs	10% coinsurance	30% coinsurance	
	Non-preferred brand drugs	10% coinsurance	30% coinsurance	
	Specialty drugs	10% coinsurance	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**. **Preauthorization** is required for spinal surgeries and **reconstructive surgery****see p.6.
	Physician/surgeon fees	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room services	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**. **Preauthorization** is required on inpatient hospital stays**see p.6.
	Physician/surgeon fee	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**. **Preauthorization** is required for inpatient hospital stay**see p.6 Partial hospitalization benefits are considered at the inpatient services benefit level.
	Mental/Behavioral health inpatient services	10% coinsurance	30% coinsurance	
	Substance use disorder outpatient services	10% coinsurance	30% coinsurance	
	Substance use disorder inpatient services	10% coinsurance	30% coinsurance	
If you are pregnant	Prenatal and postnatal care	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**.
	Delivery and all inpatient services	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**. **Preauthorization** is required on inpatient hospital stays**see p.6.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is subject to **UCR** and **preauthorization*** see p.6. Limited to 100 visits per calendar year.
	Rehabilitation services	10% coinsurance	30% coinsurance	Restorative ST and chiropractic services are limited to 25 visits. PT, OT, acupuncture, and massage therapy are limited to a combined 25 visits. **Preauthorization** is required after visit limitation has been reached as condition of coverage.
	Habilitation services	10% coinsurance	30% coinsurance	Coverage at **UCR**, only if **medically necessary**.
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is subject to **UCR**. A 90-day limit applies to coverage. **Preauthorization** is required** see p.6
	Durable medical equipment	10% coinsurance	30% coinsurance	Coverage is subject to **preauthorization** if rentals are over $500, prosthesis over $1,000, and other purchases over $1,500* see p.6. Coverage is subject to **UCR**.
	Hospice service	10% coinsurance	10% coinsurance	Coverage is subject to **UCR**. Lifetime maximum for hospice care is $50,000.
If your child needs dental or eye care	Eye exam	Not covered.	Not covered.	No coverage for these services.
	Glasses	Not covered.	Not covered.	
	Dental check-up	Not covered.	Not covered.	

***Preauthorize Services (where noted under Common Medical Events):** Failure to preauthorize services for medical necessity will result in a 20% reduction in charges considered as eligible services.
****Preauthorize Services (where noted under Common Medical Events):** Failure to preauthorize services for medical necessity will result in a 20% reduction in charges considered as eligible services. For Choice Plus plans, the provider is responsible for preauthorization and any penalty.

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.)

- Cosmetic surgery
- Dental care
- Eye exam
- Glasses
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S. See page 7 for more information
- Private-duty nursing

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 does 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 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:

Retirees and Prescription Drug Coverage: If you are a retiree, you and your dependents for whom Medicare is the primary insurer are NOT eligible to participate in the Prescription Drug Benefit under the plan. Further, as a retiree with Medicare primary insurance, your prescription drug expenses fall outside of the plan and do not count towards the plan's deductible or annual out-of-pocket coinsurance maximum.

Coverage While Traveling Outside the United States: In order for a service obtained outside the U.S. to be covered, the information provided to the plan must include: service must be a recognized service in the U.S.; all bills and/or records must be translated into English; bills must show the patient's name, provider's name, date of service, diagnosis and a description of the services rendered; and the money exchange rate with the bill showing the daily rate for the service dates. The participant is required to pay for all services up front before submitting bills 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** $5,440
- **Patient pays** $ 2,100

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:

Deductibles	$1,500
Copays	$0
Coinsurance	$600
Limits or exclusions	$0
Total	**$2,100**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,500
- **Patient pays** $ 1,900

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:

Deductibles	$1,500
Copays	$0
Coinsurance	$400
Limits or exclusions	$0
Total	**$1,900**

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. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

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.

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.