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 if you want more detail about your coverage and costs, you can get the complete terms in the Plan document(s) by contacting your Benefits Administrator, by calling 1-866-673-2299 or by visiting us at cooperative.com > My Benefits. For definitions of common terms, such as allowed amount,[1] balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. **You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-866-673-2299 to request a copy.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$50	Generally, you must pay all of the costs, including the allowed amount,[1] from providers up to the deductible amount before this Plan begins to pay. If you have other family members on the Plan, each family member must meet their own deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. For example, this Plan covers certain preventive services without cost-sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this Plan?	Not Applicable.	This Plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not Applicable.	This Plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Not Applicable.	This Plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ 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)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not covered.	Not covered.	None
	Specialist visit	Not covered.	Not covered.	
	Preventive care[1]/screening/immunization	Not covered.	Not covered.	
If you have a test	Diagnostic test (x-ray, blood work)	Not covered.	Not covered.	None
	Imaging (CT/PET scans, MRIs)	Not covered.	Not covered.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cooperative.com> My Benefits	Generic drugs (Tier 1)	Not covered.	Not covered.	None
	Preferred brand drugs (Tier 2)	Not covered.	Not covered.	
	Non-preferred brand drugs (Tier 3)	Not covered.	Not covered.	
	Specialty drugs (Tier 4)	Not covered.	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not covered.	Not covered.	None
	Physician/surgeon fees	Not covered.	Not covered.	
If you need immediate medical attention	Emergency room care	Not covered.	Not covered.	None
	Emergency medical transportation	Not covered.	Not covered.	
	Urgent care: Part of a hospital	Not covered.	Not covered.	
	Urgent care: Not part of a hospital	Not covered.	Not covered.	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not covered.	Not covered.	None
	Physician/surgeon fees	Not covered.	Not covered.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered.	Not covered.	None
	Inpatient services	Not covered.	Not covered.	
If you are pregnant	Office visits	Not covered.	Not covered.	None
	Childbirth/delivery professional services	Not covered.	Not covered.	
	Childbirth/delivery facility services	Not covered.	Not covered.	
If you need help recovering or have other special health needs	Home health care	Not covered.	Not covered.	None
	Rehabilitation services	Not covered.	Not covered.	
	Habilitation services	Not covered.	Not covered.	
	Skilled nursing care	Not covered.	Not covered.	
	Durable medical equipment	Not covered.	Not covered.	
	Hospice services	Not covered.	Not covered.	
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	None
	Children's glasses	Not covered.	Not covered.	None
	Children's dental check-up	No charge.	No charge.	Subject to allowed amount.[1] Limited to two visits per participant per calendar year.

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
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Eye exam
- Glasses
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Dental care (Adult)
- Non-emergency care when traveling outside the U.S.[2]

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 dental 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 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 Plan provide Minimum Essential Coverage? **No**.
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? **No**.
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 1-866-673-2299.

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:

1 **Allowed Amount:** UCR - Referred to as Reasonable and Customary (R&C) Rates in the medical Plan materials, allowed amounts are the current, most common rates in a geographic area for a particular treatment or service. They are researched and reviewed by Cooperative Benefit Administrators, Inc. (CBA) on a regular basis.

2 **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 the following: the service must be a recognized service in the U.S.; 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 is 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 section.

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	$0
Specialist copayment	$0
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$12,700
The total Peg would pay is	**$12,700**

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

The Plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$5,600
The total Joe would pay is	**$5,600**

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

The Plan's overall deductible	$0
Specialist copayment	$0
Hospital (facility) coinsurance	100%
Other coinsurance	100%

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	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,800
The total Mia would pay is	**$2,800**

* **Note**: This condition is not covered under the Dental Plan. The covered individual is responsible for 100%.