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[2], balance billing,[5] 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?	For network providers $750/individual or $1,500/family; for out-of-network providers $1,500/individual or $3,000/family.	Generally, you must pay all of the costs, including the allowed amount,[2] from providers up to the deductible amount before this Plan begins to pay for covered services. If you have other family members on the Plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care[1] services and physician office calls administered by network providers are not subject to the deductible.	This Plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this Plan covers certain preventive services[1] without cost-sharing and before you meet your deductible. See a list of covered preventive services[1] at https://www.healthcare.gov/coverage/preventive-care-benefits/.
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?	For network providers $7,150/individual or $14,300/family; for out-of-network providers you will continue to incur provider and prescription drug copays for out-of-network providers services.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this Plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. For network providers once you meet your network deductible ($750/individual or $1,500/family) and in-network coinsurance maximum ($0/individual or $0/family), you will continue to incur provider and prescription drug copays until you reach your network provider out-of-pocket limit. For out-of-network providers once you meet your out-of-network deductible ($1,500/individual or $3,000/family) and out-of-network coinsurance maximum ($1,200/individual or $2,400/family), you will continue to incur provider and prescription drug copays for out-of-network providers services.

What is not included in the out-of-pocket limit?	Premiums, balance billing[5] charges, out-of-network provider copayment, penalties for failure to obtain Preauthorization[3] for services and health care this Plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.cooperative.com> My Benefits or call 1-866-673-2299 for a list of network providers.	This Plan uses a provider network. You will pay less if you use a provider in the Plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays (balance billing[5]). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral. Preauthorization[3] and participation in the Center of Excellence (COE) is mandatory for both bariatric and transplant services.

⚠ 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	$40/office visit, not subject to the deductible.	20% coinsurance	Subject to allowed amount.[2] If you consult with a Teladoc physician for a general medical condition, you pay $0 copayment /consultation.
	Specialist visit	$40/office visit, not subject to the deductible.	20% coinsurance	
	Preventive care/screening/ Immunization[1]	No charge.	20% coinsurance	Subject to allowed amount.[2] Age and gender limitations apply. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your Plan will pay for.

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 have a test	Diagnostic test (x-ray, blood work)	No charge.	20% coinsurance	Subject to allowed amount.[2]
	Imaging (CT/PET scans, MRIs)	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for all non-emergency, outpatient imaging.
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)	Retail, $15 Mail-order, $0	Retail, $15 Mail-order, $0	Covers up to a 30-day supply (retail); up to a 90-day supply (mail order & Exclusive Choice pharmacies). Subject to allowed amount[2] and preauthorization[3] is required for compound drugs greater than $300, specialty drugs or nonformulary drugs. Generic drugs are available at no cost through the Exclusive Choice network (including mail order).
	Preferred brand drugs (Tier 2)	Retail, $30 Mail-order, $60	Retail, $30 Mail-order, $60	
	Non-preferred brand drugs (Tier 3)	Retail, $50 Mail-order, $100	Retail, $50 Mail-order, $100	
	Specialty drugs (Tier 4)	Generic: 30% (max $100) Preferred Brand: 30% (max $300) Non-Preferred Brand: 30% (max $500) copay/prescription	Not covered.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for non-emergency inpatient hospital stays.
	Physician/surgeon fees	No charge.	20% coinsurance	Subject to allowed amount.[2]
If you need immediate medical attention	Emergency room care	$100 copayment, subject to $750 deductible.	$100 copayment, subject to $750 deductible.	Subject to allowed amount,[2] copayment or coinsurance and deductible (if applicable). **For outpatient Emergency room care**
	Emergency medical transportation	No charge.	No charge.	

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)	
	Urgent care: Part of a hospital	$100 copayment, subject to $750 deductible.	$100 copayment, subject to $750 deductible.	**visits that are not an actual medical emergency at an out-of-network provider will be subject to the out-of-network deductible and coinsurance.** **Note:** Urgent care is paid as an office visit, unless it is part of a hospital urgent care center.
	Urgent care: Not part of a hospital	$40/office visit, not subject to the deductible.	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required for non-emergency inpatient hospital stays.
	Physician/surgeon fee	No charge.	20% coinsurance	Subject to allowed amount.[2]

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	$40/office visit, not subject to the deductible.	20% coinsurance	Subject to allowed amount.[2] Teladoc is paid at 100% after you meet your office copay. Teladoc fees are waived for services received through December 31, 2024. Preauthorization[3] is required for non-emergency inpatient hospital stays. Partial hospitalization benefits are considered at the inpatient services benefit level.
	Inpatient services	No charge.	20% coinsurance	
If you are pregnant	Office visits	$40/office visit, not subject to the deductible.	20% coinsurance	Cost sharing does not apply to certain preventive services.[1] Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Subject to allowed amount.[2] Preauthorization[3] is required for non-emergency inpatient hospital stays.
	Childbirth/delivery professional service	No charge.	20% coinsurance	
	Childbirth/delivery facility services	No charge.	20% coinsurance	

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 help recovering or have other special health needs	Home health care	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization.[3] Limited to 100 visits/ year.
	Rehabilitation services	No charge.	20% coinsurance	Subject to allowed amount.[2] Preauthorization[3] is required after visit limitation has been reached. Restorative speech therapy and chiropractic services are limited to 25 visits each. Acupuncture, physical, occupational, and massage therapy are limited to a combined 25 visits.
	Habilitation services	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization.[3]
	Skilled nursing care	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization[3] and limited to 90-day limit.
	Durable medical equipment	No charge.	20% coinsurance	Subject to allowed amount[2] and preauthorization[3] is required (if the dollar amount is equal to or greater than the following amounts) for rentals $500, prosthesis $1,000 and purchases $1,500.
	Hospice services	No charge.	No charge.	Subject to allowed amount.[2] Lifetime maximum for hospice services is $50,000.
If your child needs dental or eye care	Children's eye exam	Not covered.	Not covered.	No coverage for this service.
	Children's glasses	Not covered.	Not covered.	
	Children's dental check-up	Not covered.	Not covered.	

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.)

- Cosmetic surgery
- Dental care (Adult)
- Eye exam
- Glasses
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.[4]
- Private-duty nursing

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 the 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 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 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? **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 1-866-673-2299.

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 **Preventive Services, Preventive Care:** Under Section 2713 of the Affordable Care Act, the Plan must provide coverage for a range of preventive services and may not impose Cost sharing (such as copayments, deductibles, or co-insurance) on participants receiving these services. The required preventive services come from recommendations made by four expert medical and scientific bodies – the U.S. Preventive services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services. Only preventive services recommended by one of these four groups are covered without Cost sharing.

2 **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.

3 **Preauthorize, Prior Authorization, or Prior Approval:**

- **Medical Plan Services and Supplies**. Failure to receive preauthorization for medical necessity will result in a 20% reduction in charges considered covered by the medical Plan. If such services or supplies are later determined not to be medically necessary, the services or supplies will be denied and not eligible for coverage under the medical Plan. You will be responsible for requesting preauthorization and the expenses for failure to obtain preauthorization. Exception: If you access the Choice Plus network, the provider is responsible for your preauthorization of an in-patient hospital admission and the expenses for failure to obtain preauthorization.
- **Prescription Drugs and Supplies**. Compound drugs greater than $300 and certain drugs and drug classes require Prior Authorization by CBA or CVS Caremark. Refer to your medical Plan summary plan description for more information or contact CBA at 1-866-673-2299.

4 **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.

5 **Surprise billing and the No Surprises Act**: There are certain balance billing protections to protect consumers from getting a balance bill calculated at the out-of-network rate for out-of-network emergency services or when consumers have a scheduled procedure at an in-network hospital or surgery facility and are seen by an out-of-network provider. Note that some balance billing protections are waivable. Click here for more information.

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*	$750
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$750
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$790**

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	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$750
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,150**

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

The Plan's overall deductible	$750
Specialist copayment	$40
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$750
Copayments**	$220
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$970**

***Note:** This charge does **NOT** include facility charges for the newborn baby. Charges for the newborn baby would be subject to an individual deductible.
****Note:** This Plan has other copayments for emergency room care included in this coverage example. Review the charts in this SBC to determine how much you pay for covered emergency room care.
*****Note**: These cost sharing examples are based on generic prescription drugs.
[The Plan would be responsible for the other costs of these EXAMPLE covered services.]