MEMBERSHIP BOOKLET

# Health Access Co-op Direct Membership Benefits

## Contents

01 About Co-op Direct

02 Definitions

03 Membership Eligibility & Enrollment Requirements

04 Payment of Medical Expenses

05 Table of Eligible Medical Expenses

06 Confidentiality

07 Limitations & Exclusions

08 Exclusions

09 Appeals

# 01 About Co-op Direct

Health Access Cooperative Direct (Co-op Direct) is not health insurance; it is a consumer cooperative that provides affordable health care tailored to you, as a member, and to your health care needs. This model allows members to avoid the costly overhead associated with insurance companies, ensuring more of their investment goes directly into care.

Co-op Direct is a proven approach that allows you to stop funding insurance company profits and instead join together with other individuals to access affordable health care on your terms. We are truly patient-centered because we are owned and operated by the very people we serve. Customer service and satisfaction are our measures of success, not profit.

Co-op Direct was developed to provide individuals and families access to real health care with financial security. We have stayed true to our core focus of delivering higher-value care with more financial security by taking a cooperative approach.

Because we do not use a provider network, you are free to seek care from the medical professional of your choosing as a self-pay patient.

### WHAT WE BELIEVE

- → Health care should be centered around the doctor–patient relationship, and that is where health care decisions should be made.
- → Patients should have the freedom to seek care from the medical professional of their choosing, without arbitrary network limitations.
- → A cooperative approach can deliver higher-value care with more financial security than traditional insurance.

# 02 Definitions

| TERM | DEFINITION |
|---|---|
| **Benefits** | Eligible medical expenses of members paid by the Cooperative. |
| **Cooperative / Co-op Direct** | A member-owned and operated organization formed to provide benefits to its membership. |
| **Custodial Membership** | A membership held by a sponsoring adult who is not a member, to extend Cooperative benefits to a minor child. |
| **Dependent Child** | A member's child — biological, adopted, or through legal guardianship — under age 26, including the child of a member's spouse or domestic partner. |
| **Medical Incident** | A single accident or illness where eligible expenses exceed the Per-Incident Deductible. To be considered one incident, the deductible must be met within a 12-month period. |
| **Per-Incident Deductible** | The amount a member is responsible for paying per medical incident. |
| **Member Maximum** | The total a member pays within a 12-month period for eligible expenses unrelated to a Per-Incident Deductible — sometimes called the out-of-pocket (OOP) responsibility. |
| **Self-pay** | A member's status with providers. Because the Cooperative uses no network, members access any provider and are treated as paying directly. |
| **Waiting Period** | The time a member must be enrolled before benefits are payable for conditions that existed prior to membership. |

# 03 Membership Eligibility & Enrollment Requirements

## MONTHLY COST BY AGE BAND

Your monthly contribution depends on the deductible you choose and the age of each person on the membership.

**Co-op Direct 1000**
$1,000 per-incident deductible

| AGE BAND | MONTHLY |
|---|---|
| 0–19 | **$160** |
| 20–29 | **$217** |
| 30–39 | **$248** |
| 40–49 | **$268** |
| 50–59 | **$387** |
| 60–64 | **$500** |

**Co-op Direct 2500**
$2,500 per-incident deductible

| AGE BAND | MONTHLY |
|---|---|
| 0–19 | **$129** |
| 20–29 | **$165** |
| 30–39 | **$186** |
| 40–49 | **$206** |
| 50–59 | **$304** |
| 60–64 | **$382** |

**Co-op Direct 4000**
$4,000 per-incident deductible

| AGE BAND | MONTHLY |
|---|---|
| 0–19 | **$114** |
| 20–29 | **$145** |
| 30–39 | **$165** |
| 40–49 | **$186** |
| 50–59 | **$258** |
| 60–64 | **$330** |

**How to read these rates**

Each person on your membership is priced in the band matching their age. Add the bands together for your household total. A $75/mo tobacco surcharge applies where applicable.

Individuals, their spouse or domestic partner, and dependents may participate under individual memberships. For individual memberships, at least one family member must be 18 years old or older. Individual members remain eligible to participate up to age 65. A minor child may also be an individual member through Custodial Membership; the custodian must be at least 18 years old.

Individual members may discontinue their membership at any time by contacting Health Access Solutions and discontinuing payment.

Grandchildren may be included as part of the grandparent's membership provided the grandparent has legal custody of the grandchild.

# 03 Membership Eligibility & Enrollment Requirements (continued)

### IF AN ADULT MEMBER DIES

- For an Individual membership, the membership terminates as of the date of death.
- For Individual + Spouse/Domestic Partner or Family memberships, if the primary member passes away, the membership continues automatically for 30 days (“transition period”) and the membership fee is waived for that transition period. Once the transition period expires, membership will terminate. The surviving spouse/domestic partner, or guardian of a minor child, can elect to become the primary member.
- Family members are required to provide Health Access Cooperative with notice of the adult member’s death within 30 days after the date of death.

## Processing Payment Requests After a Death

In the event of a member’s death, the Cooperative will only discuss and process payment requests with an authorized legal representative of the member’s estate — such as an executor, personal representative, or administrator appointed pursuant to applicable law. To establish authority, the Cooperative requires a copy of the death certificate and documentation establishing legal authority to act on behalf of the estate, such as letters testamentary or letters of administration.

For payment requests involving a surviving spouse who was enrolled under the same membership, a death certificate and proof of marriage may be sufficient at the Cooperative’s discretion; spouses who already have permission to process payment requests on behalf of their family may do so under existing authorizations.

Open payment requests at the time of death will be processed in accordance with the membership terms applicable at the date of service.

# 04 Payment of Medical Expenses

In the event that a member is covered by any insurance or government assistance plans, those plans will be primary payers and the Cooperative will pay secondary.

Members are responsible for a Per-Incident Deductible for each accident or illness. Once eligible medical expenses for an incident exceed the applicable Per-Incident Deductible, the Cooperative pays 100% of remaining eligible expenses, subject to eligibility limitations.

Per-Incident Deductibles do not reset for a medical incident until and unless a member goes 12 months treatment-free.

Members will only be responsible for up to two (2) Per-Incident Deductibles per calendar year regardless of their enrollment tier.

Unreimbursed eligible expenses not associated with an incident, as well as certain designated services, are subject to an annual calendar-year Member Maximum, after which the Cooperative will pay or reimburse expenses above the maximum at 100% for the balance of the calendar year.

### CARE FROM THE PROVIDER OF YOUR CHOOSING

The Cooperative does not utilize provider networks, so members are free to utilize the medical provider of their choosing:

- Members present themselves as self-pay patients.
- Always ask for self-pay discounts if not offered.
- Itemized invoices/ receipts for services provided in a calendar year must be submitted by June 30 of the subsequent calendar year. Exceptions may be made for late invoice submissions outside of the member's control.

Members are encouraged to contact the member services team prior to non-emergency services so our team can best support managing payment of services through your care journey.

For payment questions in the event of a death of the primary member, please see "Processing Payment Requests After a Death."

# 04 Payment of Medical Expenses (continued)

### PAYMENT REQUEST

Your Member Portal is where you will submit and manage your payment requests. Through the portal, you can securely submit new payment requests, upload supporting documentation — including fully itemized bills — review request details, and track the status of your requests throughout the review process. You can access your Member Portal anytime to view updates, respond to requests for additional information, and stay informed.

### INTERNATIONAL CARE

Urgent or emergent care while traveling internationally is eligible for reimbursement. A translated documentation required for processing. To help ensure accurate reimbursement, we kindly ask that payment be made through a U.S.-based financial institution or credit card, as reimbursement will be based on the U.S. dollar amount reflected in the transaction record.

If you are considering planned care abroad — such as a lower-cost surgery or procedure — please contact the Member Services Team before making any travel arrangements. The Director will review options on a case-by-case basis. Travel and lodging costs may or may not be included (see Exclusions).

# 05 Table of Eligible Medical Expenses

### UNDERSTANDING YOUR CO-OP DIRECT COSTS

Your membership manages out-of-pocket costs in two ways: the Per-Incident Deductible and the Member Maximum. They work differently, and understanding the difference helps you know what to expect when a bill arrives.

The Per-Incident Deductible applies when a specific event occurs where the total eligible expenses exceed the amount of your deductible. This could be for an illness, an injury, a surgery, or a new baby. One event means one deductible. After it is met, Co-op Direct pays 100% of eligible expenses related to that incident.

The Member Maximum applies to smaller eligible expenses less than your deductible that are not otherwise connected to an incident. These expenses accumulate over the year toward an annual ceiling. Once it is met, Co-op Direct pays 100% of your remaining eligible expenses through the end of the calendar year.

Together, the Per-Incident Deductible limits your costs for any individual expensive medical event, while the Member Maximum caps your overall costs for smaller, unrelated medical expenses.

### MEMBERSHIP OPTIONS

| MEMBERSHIP OPTION | PER-INCIDENT DEDUCTIBLE | MEMBER MAXIMUM (INDIVIDUAL / FAMILY) |
|---|---|---|
| **Option 1** | $1,000 (capped at 2 per family per year) | $4,000 / $8,000 |
| **Option 2** | $2,500 (capped at 2 per family per year) | |
| **Option 3** | $4,000 (capped at 2 per family per year) | |

Member Maximum applies to unreimbursed eligible expenses unrelated to a Per-Incident Deductible.

### ELIGIBLE SERVICES

Services shown in **blue** are paid at 100% after the Member Maximum only.

| SERVICE | CO-OP DIRECT PAYS | IMPORTANT INFORMATION |
|---|---|---|
| **Acupuncture** | 100% after Member Maximum. | Limited to 15 visits per year. |

# 05 Table of Eligible Medical Expenses (continued)

| SERVICE | CO-OP DIRECT PAYS | IMPORTANT INFORMATION |
|---|---|---|
| **Allergy services — office visit, injections, serum, testing** | 100% after Member Maximum. | |
| **Ambulance** | 100% after per-incident deductible/ Member Maximum * | |
| **Ambulatory surgical center / hospital outpatient facility** | 100% after per-incident deductible/ Member Maximum * | |
| **Birth control — IUD insertion & removal** | 100% after per-incident deductible/ Member Maximum * | One incident if services are rendered on the same day and limited to $3000 per incident. |
| **Chemotherapy** | 100% after per-incident deductible/ Member Maximum * | |
| **Chiropractic care** | 100% after per-incident deductible/ Member Maximum * | Limited to 35 visits, up to $7,500 per incident. |
| **Diabetic supplies** | 100% after Member Maximum. | Up to $3,000 per year. |
| **Dialysis services** | 100% after per-incident deductible/ Member Maximum * | |
| **Diagnostic — lab, X-ray & other diagnostic services, high-tech radiology (MRI, CT, PET)** | 100% after per-incident deductible/ Member Maximum * | |
| **Durable medical equipment** | 100% after per-incident deductible/ Member Maximum * | |
| **Emergency room services** | 100% after per-incident deductible/ Member Maximum * | |
| **Extended care / skilled nursing / rehabilitation facility** | 100% after per-incident deductible/ Member Maximum * | Limited to 90 days per incident. |
| **Foot orthotics** | 100% after per-incident deductible/ Member Maximum * | Limited to one pair per year. |
| **Hearing aid** | 100% after Member Maximum. | Children up to 18; one per ear every 36 months. |

# 05 Table of Eligible Medical Expenses (continued)

| SERVICE | CO-OP DIRECT PAYS | IMPORTANT INFORMATION |
|---|---|---|
| **Home health care** | 100% after per-incident deductible/ Member Maximum * | Limited to 30 days per incident. |
| **Hospice care** | 100% after per-incident deductible/ Member Maximum * | Limited to 90 days. |
| **Hospital inpatient — room & board, ancillary services** | 100% after per-incident deductible/ Member Maximum * | |
| **Hyperbaric therapy** | 100% after per-incident deductible/ Member Maximum * | Outpatient only; up to 35 sessions per incident. |
| **Infertility related services** | 100% after per-incident deductible/ Member Maximum * | Limited to $3,000 per incident. |
| **Injections for pain management** | 100% after per-incident deductible/ Member Maximum * | Limited to $3,000 per incident. |
| **Lyme Disease** | 100% after per-incident deductible/ Member Maximum * | Limited to $7,500 per incident. |
| **Mental health — inpatient, partial hospitalization, outpatient** | 100% after per-incident deductible/ Member Maximum * | Limited to $6,000 per incident. |
| **Physician services — office, specialist, inpatient** | 100% after per-incident deductible/ Member Maximum * | |
| **Prosthetics, orthotics, supplies & surgical dressings** | 100% after per-incident deductible/ Member Maximum * | |
| **Radiation therapy** | 100% after per-incident deductible/ Member Maximum * | |
| **Sleep apnea** | 100% after Member Maximum. | Limited to $3,000 for all sleep apnea treatment and services, with an additional cap of $300 on the sleep study. |
| **Sterilization** | 100% after per-incident deductible/ Member Maximum * | Limited to $3,000 per incident. |

# 05 Table of Eligible Medical Expenses (continued)

| SERVICE | CO-OP DIRECT PAYS | IMPORTANT INFORMATION |
|---|---|---|
| **Substance abuse — inpatient, partial hospitalization, outpatient** | 100% after per-incident deductible/ Member Maximum * | Limited to $6,000 per incident. |
| **Surgical services — inpatient & outpatient** | 100% after per-incident deductible/ Member Maximum * | Surgeon and anesthesia included. |
| **Therapy — occupational, physical & speech** | 100% after per-incident deductible/ Member Maximum * | 35 visits each; OT/PT up to $7,500, ST up to $3,000. |
| **Urgent care / walk-in center** | 100% after per-incident deductible/ Member Maximum * | |
| **Weight-reduction surgery** | 100% after per-incident deductible/ Member Maximum * | Limited to $3,000 per incident. |
| **All other eligible services** | 100% after per-incident deductible/ Member Maximum * | Eligibility at Co-op Direct's sole discretion. |

** Eligible expenses apply toward your Per-Incident Deductible if they're connected to a specific medical incident, or toward your Member Maximum if they're a smaller, unrelated expense.*

## INCLUDED SCREENINGS

| SCREENING | CO-OP DIRECT PAYS | LIMITS & NOTES |
|---|---|---|
| **Annual preventive mammogram (including breast ultrasound or MRI following a preventive mammogram)** | 100% up to allowance | Included once annually, starting at age 40. Year 1: $250 allowance. Year 2+: $500 allowance. |
| **Colorectal cancer screening — Cologuard or colonoscopy** | 100% up to allowance | Starting at age 45 (age 40 if first-degree relative has positive history). Cologuard: every 3 years. Colonoscopy: Year 1: $500 allowance. Year 2+: $1,500 allowance. |

# 05 Table of Eligible Medical Expenses (continued)

## MATERNITY & NEWBORN CARE

| SERVICE | CO-OP DIRECT PAYS | LIMITS & NOTES |
|---|---|---|
| **Pregnancy & obstetrical — prenatal, delivery & post-partum** | 100% after per-incident deductible | Existing condition waiting period applies if expected delivery is within 5 months of enrolling. Deliveries in the first year of membership will have a $7,500 per-incident deductible; Year 2+ the standard deductible applies. |
| **Hospital / birthing center** | 100% after per-incident deductible | — |
| **Well-newborn nursery care (at birth)** | 100% after per-incident deductible | Newborn must be added within 30 days from birth. |
| **Newborn circumcision** | 100% after per-incident deductible | — |
| **Breast pump** | 100% after per-incident deductible | Up to $300. |

## PRESCRIPTION MEDICATIONS

| SERVICE | CO-OP DIRECT PAYS | LIMITS & NOTES |
|---|---|---|
| **Prescription drugs billed by a provider during an incident** | 100% after per-incident deductible | Prescriptions that are short term or curative in nature such as antibiotics, chemotherapy, and short-term pain medications. |
| **Specialty maintenance medications (over $1,000 / month)** | 100% after $2,500 | Newly prescribed only; reimbursed for the remainder of that year. |
| **Maintenance medications under $1,000 / month** | Discount prescription card included with membership. | Filled at a pharmacy. |
| **Over-the-counter medications** | Not eligible | — |

# 06 Confidentiality

Co-op Direct takes member confidentiality seriously. Co-op Direct safeguards member health and personally identifiable information and only uses this information for certain purposes, such as payment, consistent with the terms of the member authorization and internal policies and procedures. A copy of the ways that Co-op Direct is permitted to use your health and personally identifiable information is available upon request. To obtain a copy, please contact our Member Benefits Team.

# 07 Limitations & Exclusions

### WAITING PERIOD FOR EXISTING CONDITIONS

To keep premiums low for all members, there is a waiting period for medical conditions that exist prior to an individual's enrollment date as a new member.

There is a waiting period for any illness or injury for which in the prior 24 months a person has been:

1. Examined; or
2. Taken medications to treat or manage; or
3. Had a diagnostic test performed and/or ordered by a health professional; or
4. Received medical treatment to treat or manage.

### EXCEPTIONS TO THE WAITING PERIOD

#### *EXCEPTIONS TO THE WAITING PERIOD

For the following, the waiting periods do not apply:

- Conditions cured more than 24 months ago and untreated since.
- Well-managed high blood pressure, cholesterol and diabetes (no hospitalization in the prior 12 months).
- Cancer in remission 6+ years with negative scans.

---

Maternity is subject to the existing condition waiting period if you are more than four months pregnant as of your effective date.

Existing condition waiting periods (individual members) — amount available:

| YEAR 1 | YEAR 2 | YEAR 3 | YEAR 4+ |
|---|---|---|---|
| **$0** | **$25,000** | **$50,000** | **Unlimited** |

# 07 Limitations & Exclusions (continued)

### TOBACCO

If the primary member and/or spouse/domestic partner on your membership is a tobacco user, a $75 monthly surcharge applies. A tobacco user is anyone who used a tobacco product(s) in the past year — including cigarettes, cigars, chewing tobacco, snuff, vape products, pipe tobacco, nicotine pouches, and smoked cannabis. The surcharge may be dropped after 12 consecutive tobacco-free months. Tobacco users aged 50 or older have a $50,000 lifetime limit per incident for stroke, cancer, heart conditions and COPD — which remains even after quitting.

### PRESCRIPTION MEDICATIONS

Prescription drugs tied to an eligible medical incident that are short-term or curative in nature, such as antibiotics, chemotherapy, and short-term pain medications are eligible at 100% after per-incident deductible.

Maintenance medications filled at a pharmacy are not eligible under Co-op Direct except for newly prescribed specialty maintenance medications. Members have access to some of the lowest-priced prescription medications locally or by mail order, including international mail order - please see your drug card for discounts.

### SPECIALTY MAINTENANCE MEDICATIONS

Specialty Maintenance Medications are medications that are prescribed long-term and cost more than $1,000 a month.

If a member has a newly prescribed specialty maintenance medication after the membership start date, members will be responsible for the first $2,500, then Co-op Direct will reimburse the costs above that for the remainder of that year only.

Individuals with a specialty medication may also be able to access the drug more affordably through international mail order or manufacturer assistance. Please contact the Member Services Team for guidance on available resources.

See the member benefit summary for additional details.

# 08 Exclusions

**After termination date**

Expenses that are incurred by the member on or after the date membership terminates, even if payments have been predetermined for a course of treatment submitted before the termination date.

**Cosmetic surgery**

Expenses that are incurred in connection with the care and/or treatment of surgical procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an accident; (b) because of infection or illness; (c) because of congenital disease, developmental condition or anomaly of a member's Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to injury, illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

**Custodial care**

Expenses that do not restore health or are provided mainly as a rest cure or for maintenance care, unless specifically mentioned otherwise.

**Dental**

Expenses that are for or in connection with dental services or supplies, including temporomandibular joint (TMJ).

**Experimental**

Expenses for medical services that are experimental or investigational.

**Illegal act**

Charges incurred for any loss to which a contributing cause was the member's commission of or attempt to commit a felony or to which a contributing cause was the member's being engaged in an illegal occupation. This exclusion does not apply if the injury (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

**Long-term care**

Expenses related to long-term care.

# 08 Exclusions (continued)

**Medical necessity**

Expenses for services and/or supplies that are not medically necessary. “Medical Necessity” means health care services that a physician, exercising prudent clinical judgment, would provide to a patient. The service must be:

- For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms;
- In accordance with the generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient’s illness, injury, or disease;
- Not primarily for the convenience of the patient, health care provider, or other physicians or health care providers;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury, or disease.

**Negligence**

Expenses for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any caregiver, institution, or provider, as determined by the Co-op Direct Board, in its discretion, in light of applicable laws and evidence available.

**Occupational**

Expenses that are For or in connection with an illness or an injury covered under any workers’ compensation or similar law.

**Prohibited by law**

Expenses paid under this membership to the extent that such payment is prohibited by law.

**Self-inflicted**

Expenses incurred due to an intentionally self-inflicted injury or illness, unless such self-inflicted injury or illness is the result of domestic violence, or (b) a documented medical condition (including both physical and mental health conditions).

**Sex reassignment and gender-affirming services**

Services, medications, treatments, or procedures performed for the purpose of reassigning sex, altering gender, or affirming gender identity.

# 08 Exclusions (continued)

**Subrogation, reimbursement, and/or third-party responsibility**

For clarity, if any third party is obligated under any law or contract to pay for expenses related to a member's illness or injury, Co-op Direct will not pay for such expenses until such third party's obligation is paid in full, and then Co-op Direct will only pay the difference between the payable amount of the expense and the amount paid by the third party. Examples of such third parties include but are not limited to: employers, health insurance, auto insurance, lawsuit defendants, and workers' compensation.

**Travel & lodging**

Routine travel — such as to the provider of your choice — is not eligible.

**War / riot**

Expenses incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the member is a member of the armed forces of any country, or during service by a member in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any member who is not a member of the armed forces and does not apply to victims of any act of war or aggression.

# 09 Appeals

If Co-op Direct determines that a medical expense is not payable under a member's membership, the member may appeal that determination by sending a letter of appeal by email to: coopappeals@healthaccesssolutions.com . Appeals must be submitted within 60 days of the date of Co-op Direct's determination.

The member may also send a written letter of appeal to the following address:

**Cooperative Appeals 1566 S Gilbert St Unit #1008 Iowa City, IA 52240**

The letter of appeal should include any information and discussion (including attachments and enclosures) the member believes are relevant to Co-op Direct's determination.