

Health Access Cooperative—Direct For Individuals

Membership Booklet

Health Access Solutions

Health Access Cooperative—Direct for Individuals

The Health Access Cooperative—Direct for Individuals (Co-op Direct) is not health insurance; it's 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.

Owned and operated by our members, Health Access Cooperative prioritizes patient needs and satisfaction. This structure means we're focused on delivering the best service and health care experience possible. Your health is our priority, not profit. We have stayed true to our core focus of providing real access to health care with financial security for you and your family. [1]

We believe health care should be centered around the doctor-patient relationship and that is where health care decisions should be made.

We believe that patients should have the freedom to seek care from the medical professional of their choosing and not be restricted by arbitrary network limitations.

We believe that health insurance has failed to provide affordable premiums for many in our country and it shifts an unfair burden of out-of-pocket costs onto patients. We can provide higher-value care with more financial security by taking a cooperative approach.

[1] Membership in the Health Access Cooperative may not satisfy state-mandated insurance coverage requirements.

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Definitions

Benefits: Eligible medical expenses of members paid by the Cooperative.

Cooperative: 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, through adoption or legal guardianship, who is under the age of 26, including the child of a covered spouse or domestic partner.

Medical Incident: A single accident or illness where eligible medical expenses exceed the Per-Incident Deductible.

Per-Incident Deductible: The amount a member is responsible for paying per medical incident.

Member Maximum: The total amount members are responsible for paying per calendar year for eligible expenses unrelated to a Per-Incident Deductible. This is sometimes referred to as a member's "out-of-pocket" responsibility or OOP responsibility.

Self-pay: Refers to members' status with health care providers. The Cooperative does not use a provider network, so members are free to access any health care provider and are treated as a patient paying directly versus utilizing an insurance network.

Waiting Period: The time frame that a member must be enrolled in the Cooperative before benefits are payable by the Cooperative for health conditions that existed prior to membership.

Membership Eligibility

Individuals, their spouse or domestic partner, and dependents may participate in the Health Access Cooperative through Co-op Direct memberships. For Co-op Direct memberships, at least one family member must be 18 years old or older. Individuals 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.

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

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

In the event an adult member dies, the following rules apply:

- For an individual, the membership terminates as of the date of death.
- For an individual with a surviving spouse or domestic partner on the membership, the membership continues automatically after the adult member's death unless otherwise terminated by the surviving spouse or domestic partner.
- For an individual with no surviving spouse or domestic partner on the membership, but with one or more minor dependents on their membership, or any other circumstance in which the death of the adult member leaves no remaining adult in the household, 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 unless a Custodial Membership is established by a grandparent or other guardian.
- 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.
- Membership fees will be adjusted if appropriate.

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. An incident is a single accident or illness. The medical expenses associated with an incident will be aggregated when applying the Per-Incident Deductible. The Cooperative pays all eligible expenses related to an incident at 100% after the applicable Per-Incident Deductible.

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.

Unreimbursed eligible expenses not associated with an incident 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.

We do 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.
- Invoices 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.
- For terminated members, expenses incurred while membership was active should be submitted within 6 months of the membership termination date.

We encourage contacting our Member Support Team in advance of non-preventive/routine medical procedures whenever possible. We will assist with bill negotiations when possible and prefer to pay providers in advance of services to maximize prompt-pay discounts.

We ask our members to assist us in finding high-value care whenever possible by shopping for services when appropriate. There can be significant variation in cost for the same services at different locations. Our support team may also be able to provide recommendations for high-quality providers offering fair prices. To encourage this cooperation and create a culture of consumerism, we may reward members who seek high-value providers with incentives such as lowering Member Maximums.

Confidentiality

Health Access Cooperative takes member confidentiality seriously. Health Access Cooperative 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 Health Access Cooperative is permitted to use your health and personally identifiable information is available upon request. To obtain a copy, please contact our Member Support Team.

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:

- Conditions regarded as cured more than 24 months ago and that did not require treatment or medication in the preceding 24 months.
- High blood pressure, high cholesterol, and diabetes managed by medication and/or diet and exercise for which hospitalization has not been required in the previous 12 months.
- Cancer that has been in full remission for a minimum of 6 years for which all appropriate scans or tests have been performed and were negative.
- Maternity is subject to the existing condition waiting period if the expected delivery is within 5 months of enrolling, and deliveries within the first year of membership will have a $7,500 Per-Incident Deductible. In Year 2 and beyond, the standard Per-Incident Deductible of $1,000, $2,500, or $4,000 will apply.

Existing condition waiting periods:

- Year 1: Amount available $0
- Year 2: Amount available $25,000
- Year 3: Amount available $50,000
- Year 4+: Unlimited

Tobacco

If any person on your membership is a tobacco user, there is a $75 surcharge added to your monthly membership fee.

An individual who has used any tobacco product more than ten (10) times within the past year is considered a tobacco user. Tobacco products include, but are not limited to, cigarettes, cigars, chewing tobacco, snuff, vape products, pipe tobacco, nicotine pouches, and other nicotine products. Smoked cannabis products are considered tobacco for the purpose of the tobacco surcharge and any applicable coverage limitations.

If a tobacco user ceases tobacco usage, the premium surcharge may be dropped after 12 consecutive months tobacco-free.

Tobacco users aged 50 or older will have a lifetime limit of $50,000 for Medical Incidents for each of the following four disease categories (this benefit cap remains even if a tobacco user aged 50 or older quits tobacco use):

- Stroke
- Cancer
- Heart conditions
- Chronic obstructive pulmonary disease (COPD)

Prescription Medications

Prescriptions for medications related to a Medical Incident are considered an eligible member benefit (e.g., anti-biotics, chemotherapy, short-term pain medications, etc.) and will be included after the Per-Incident Deductible for that incident has been met.

For maintenance medications filled at a pharmacy, members have access anytime to some of the lowest-priced prescription medication locally or by mail order, including international mail order.

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 coverage start date, members will be responsible for the first $2,500, then the cooperative will reimburse the costs above that for the remainder of that year only.

See the member benefit summary for additional details.

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.
- **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 Health Access Cooperative Board, in its discretion, in light of applicable laws and evidence available.
- **Occupational:** Expenses that are:
  1. For or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit;
  2. 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:** Services or procedures performed for the purpose of reassigning sex.
- **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, the Cooperative will not pay for such expenses until such third party’s obligation is paid in full, and then the Cooperative 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.
    - **War/Riot:** That are 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.

Appeals

If the Cooperative 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.

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 the Cooperative's determination.

Covered Screenings Included with the Co-op Direct Program

Annual Preventive Mammogram (including Breast Ultrasound or MRI following a preventive mammogram)

- Covered once annually, starting at age 40
- Year 1: $250 allowance, Year 2+: $500 allowance

Colorectal Cancer Screening:

- Starting at age 45 (covered from age 40 if 1st degree relative has positive history of colon cancer)
- Screening Type: Procto/Sigmoidoscopy every 5 years. Cologuard every 3 years.
- Colonoscopy is an eligible screening type "Colonoscopy, Screening"
- Year 1: $500 allowance, Year 2+: $1,500 allowance

Table of Eligible Medical Expenses

Membership Options	Per-Incident Deductible	*Member Maximum for unreimbursed, eligible expenses unrelated to a Per-Incident Deductible (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)	
Eligible Medical Expenses	**Co-op Responsibility**	**Limits or Other Important Information**
Acupuncture	100% after Member Maximum	Limited to 15 visits per year.
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	
Birthing Center	100% after Per-Incident Deductible/Member Maximum	
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 year.
Dialysis Services	100% after Per-Incident Deductible/Member Maximum	
Diagnostic Procedures Office & Outpatient - X-ray, Laboratory and Other Diagnostic Services - High Tech Radiology (including but not limited to	100% after Per-Incident Deductible/Member Maximum	

MRI, CT/PET Scans)		
Durable Medical Equipment	100% after Per-Incident Deductible/Member Maximum	**Sleep Apnea**: sleep study expenses are eligible up to $300/study, CPAP machines and equipment are subject to Member Maximum. **Diabetic Supplies**: subject to Member Maximum and limited to $3,000 per calendar year. **Breast Pumps**: limited to $300
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.
Hearing Aid	100% after Member Maximum	Children up to 18, limited to 1 hearing aid per ear every 36 months.
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 - Well Newborn Nursery Care	100% after Per-Incident Deductible/Member Maximum	
Hyperbaric Therapy	100% after Per-Incident Deductible/Member Maximum	Limited to outpatient. Up to 35 sessions per incident.
Infertility Treatment	100% after Member Maximum	Limited to $3,000 per incident.
Injections for Pain Management	100% after Member Maximum	Limited to $3,000 per incident.
Mental Health - Inpatient Hospital - Inpatient Hospital Physician Visit - Partial Hospitalization Program - Office Visit/Outpatient Therapy	100% after Per-Incident Deductible/Member Maximum	Limited to $6,000 per incident.

Physician Services - Inpatient Hospital Visit - Well Newborn Physician and Circumcision - Office Visit- Primary Care - Office Visit- Specialist	100% after Per-Incident Deductible/Member Maximum	
Pregnancy-Obstetrical Care - Preconception and Prenatal Care - Postnatal Care - Delivery	100% after Per-Incident Deductible/Member Maximum	Maternity is subject to the existing condition waiting period if the expected delivery is within 5 months of enrolling, and deliveries within the first year of membership will have a $7,500 Per-Incident Deductible. In Year 2 and beyond, the standard Per-Incident Deductible of $1,000, $2,500, or $4,000 will apply. Member and Covered Dependents.
Prescription Medications	100% after Per-Incident Deductible/Member Maximum	When prescribed by a medical provider as part of a medical incident.
Preventive and Wellness Care	N/A	See included screenings above.
Prosthetics, Orthotics, Supplies and Surgical Dressings	100% after Per-Incident Deductible/Member Maximum	
Radiation Therapy	100% after Per-Incident Deductible/Member Maximum	
Specialty Maintenance Medications	100% after member responsibility of $2,500	Must be newly prescribed after membership start date, eligible for up to 12 months.
Sterilization	100% after Member Maximum	
Substance Abuse - Inpatient Hospital - Inpatient Hospital Physician Visit - Partial Hospitalization Program - Office Visit/Outpatient Therapy	100% after Per-Incident Deductible/Member Maximum	Limited to $6,000 per incident.

Surgical Services-Inpatient and Outpatient - Surgeon/Anesthesia Inpatient - Surgeon Outpatient - Anesthesia Outpatient - Surgeon Office/Primary - Surgeon Office/Specialist	100% after Per-Incident Deductible/Member Maximum	
Therapy -Occupational/Physical/Speech	100% after Per-Incident Deductible/Member Maximum	Limited per incident: OT, 35 visits to $7,500; ST, 35 visits to $3,000; PT, 35 visits to $7,500.
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 for services not expressly listed is at the sole discretion of the Cooperative.

Stay Healthy!

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