

**Co-op Health and Welfare Plan and Trust  
Option 1 Traditional Plan**
**Effective Date: 1/1/2026**
**PPO Benefits**

<b>Benefit Features</b>	<b>Network Providers</b>	<b>Out-of-Network Providers [1]</b>
<b>Annual Deductible</b>		
Individual	\$1,250	\$2,450
Family	No Family Limit	No Family Limit
<b>Annual Out-of-Pocket Maximum Amount</b>		
Individual	\$4,000	Unlimited
Family	\$8,000	Unlimited
<b>Dependent Age Limit</b>		To age 26
<b>Lifetime Maximum Benefit</b>		Unlimited
<b>Pre-Existing Waiting Period</b>		None
<b>4th Quarter Deductible Carryover Provision</b>		Not included
<b>Benefits for Covered Services</b>	<b>Network Benefits</b>	<b>Out-of-Network Benefits [1]</b>
<b>Practitioner Office Services</b>		
Office Visits	80% after Deductible	60% after Deductible
Routine Diagnostic Lab, X-Ray, & Injections	80% after Deductible	60% after Deductible
Advanced Radiological Imaging [4]	80% after Deductible	60% after Deductible
<b>Preventive Health Care Services</b>		
Well Child Care (under age 6)	100%	60% after Deductible
Well Care (age 6 and up)	100%	60% after Deductible
Annual Well Woman Exam	100%	60% after Deductible
Annual Mammography Screening	100%	60% after Deductible
Annual Cervical Cancer Screening	100%	60% after Deductible
Annual Prostate Cancer Screening	100%	60% after Deductible
Immunizations	100%	60% after Deductible
<b>Services Received at a Facility (includes professional and facility charges)</b>		
Inpatient Services [2]	80% after Deductible	60% after Deductible
Outpatient Surgery [3]	80% after Deductible	60% after Deductible
Routine Diagnostic Services-Outpatient	80% after Deductible	60% after Deductible
Advanced Radiological Imaging-Outpatient [4]	80% after Deductible	60% after Deductible
Other Outpatient Services [5]	80% after Deductible	60% after Deductible
Emergency Care Services	80% after Deductible	80% after Deductible
Emergency Care Advanced Radiological Imaging[4]	80% after Deductible	80% after Deductible
<b>Medical Equipment</b>		
Durable Medical Equipment, Prosthetic & Orthotic Appliances	80% after Deductible	60% after Deductible
<b>Chiropractor Services</b>		
Manipulative Therapy is limited to 20 visits per year	80% after Deductible	60% after Deductible
<b>Therapeutic Services [6]</b>		
Therapy (Limited to 30-36 visits per year per therapy type)	80% after Deductible	60% after Deductible
<b>Skilled Nursing Facility &amp; Rehabilitation Facility Services [2]</b>		
Limited to 60 days combined	80% after Deductible	60% after Deductible
<b>Home Health Services [7]</b>		
	80% after Deductible	60% after Deductible
<b>Hospice Services</b>		
	100%	60% after Deductible
<b>Ambulance Service</b>		
	80% after Deductible	80% after Deductible

**Notes:**

1. Out-of-network benefits may be based on BlueCross BlueShield of Tennessee maximum allowable charge. You may be responsible for any unpaid billed charges for certain services received from out-of-network providers. For true emergency services received at an out-of-network hospital, items and services received from an out-of-network provider at an in-network hospital (unless you give certain providers written consent), or emergent and authorized air ambulance services, in-network benefits including deductible will apply up to the qualified payment amount, and the provider may not bill you for more than your in-network cost share.
2. Services require prior approval. Benefits will be reduced to 50% for services received from network providers outside Tennessee and all out-of-network providers when prior approval is not obtained.
3. Surgeries include invasive diagnostic procedures such as colonoscopy and sigmoidoscopy.
4. CAT scans, MRIs, nuclear medicine and other similar technologies.
5. Includes services such as chemotherapy, radiation therapy, infusions, and renal dialysis.
6. Physical, speech and occupational therapies are limited to 30 visits per therapy type per year. Cardiac and pulmonary rehabilitative therapies are limited to 36 visits per therapy type per year.
7. Requires prior authorization.