Colorado Access Choice EPO Colorado Option Silver

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 to get a copy of the complete terms of coverage, visit www.coaccesschoice.com or call 1-833-575-8033. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-833-575-8033 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$5,000 / individual or $10,000 / family	Generally, you must pay all of the costs 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 individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. 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 and primary 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. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services 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?	$11,450 / individual or $22,900/ family	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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, 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.coaccesschoice.com or call 1-833-575-8033 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). 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.

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: Contracted (You will pay the least)	What You Will Pay: Non-Contracted (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay/office visit; deductible does not apply	Not covered	Includes virtual visits.
	Specialist visit	$90 copay/office visit; deductible does not apply	Not covered	Includes virtual visits.
	Preventive care/screening/ Immunization	$0 copay/office visit; deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.coaccesschoice.com	Preventive Drugs (ACA) Tier 1	$0 copay/office visit; deductible does not apply	Not covered	No cost share for eligible drugs.
	Generic drugs Tier 2	30-day supply (retail & mail order): $20 copay/prescription; deductible does not apply	Not covered	Covered up to a 90-day supply (retail & mail order); 90-day cost share is 2 times the 30-day supply.
	Preferred brand drugs Tier 3	30-day supply (retail & mail order): $125 copay/prescription; deductible does not apply	Not covered	
	Non-preferred brand drugs Tier 4	30-day supply (retail & mail order): $300 copay/prescription; deductible does not apply	Not covered	
	Specialty drugs Tier 5	30-day supply (retail& mail order): $650 copay/prescription; deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	Preauthorization may be required.
	Physician/surgeon fees	40% coinsurance	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.coaccesschoice.com

Common Medical Event	Services You May Need	What You Will Pay Contracted (You will pay the least)	Non-Contracted (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need immediate medical attention	Emergency room care	40% coinsurance	Covered same as Contracted	None
	Emergency medical transportation	40% coinsurance	Covered same as Contracted	Non-emergency Non-Contracted ambulance services are limited to $50,000 per trip, does not apply to air ambulance.
	Urgent care	$80 copay/per visit; deductible does not apply	Covered same as Contracted	Additional cost share determined based on service received.
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	Preauthorization may be required.60 days/benefit period of inpatient rehabilitation services for Contracted provider.
	Physician/surgeon fees	40% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay/office visit; deductible does not apply. All other outpatient 40% coinsurance	Not covered	None
	Inpatient services	40% coinsurance	Not covered	
If you are pregnant	Office visits	$0 copay/office visit; deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% coinsurance	Not covered	
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	40% coinsurance	Not covered	Limited to 60 visits per year.
	Rehabilitation services	40% coinsurance	Not covered	Limited to 20 visits per therapy per year. Visit limits for physical therapy, occupational therapy, and speech therapy do not apply to therapies when
	Habilitation services	40% coinsurance	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.coaccesschoice.com

Common Medical Event	Services You May Need	What You Will Pay Contracted (You will pay the least)	Non-Contracted (You will pay the most)	Limitations, Exceptions, & Other Important Information
				primary diagnosis is behavioral health/mental health/substance use disorder or to medically necessary autism spectrum disorder.
	Skilled nursing care	40% coinsurance	Not covered	Limit 100 days per calendar year
	Durable medical equipment	40% coinsurance	Not covered	Excludes items for comfort, convenience or lifestyle/non-medical use (e.g., exercise equipment, humidifiers, stockings, hygiene supplies, pools/spas, elevators).
	Hospice services	40% coinsurance	Not covered	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No charge, deductible does not apply	Not covered	Limited to 1 exam per year.
	Children's glasses	No charge, deductible does not apply	Not covered	Limited to $120 every 2 years for hardware.
	Children's dental check-up	Not covered	Not covered	None

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
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Dental care (Adult)
- Routine eye care (Adult)
- Long-term care
- Routine foot care

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

- Abortion
- Chiropractic care – Limited to 20 visits per year
- Acupuncture – Limited to 6 visits per year
- Hearing aids - Limited to 1 device per year every 60 months (under 18 years of age)
- Bariatric surgery
- Infertility treatment
- Private-duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Colorado Division of Insurance at 303-894-7490 or 800-930-3745, or visit doi.colorado.gov; or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 ext. 61565 or www.cms.gov/cciio; or contact the plan. 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 your plan, or Colorado Division of Insurance Consumer Services. To contact Colorado Access Choice member services, please call 1-833-575-8033, TTY users should call 711, or visit us at www.coaccesschoice.com.

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? Not Applicable

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.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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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** **$5,000**

- **Specialist *[cost sharing]*** **$90**
- **Hospital (facility) *[cost sharing]*** ***40%***
- **Other *[cost sharing]*** ***40%***

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	$5,000
Copayments	$10
Coinsurance	$3,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$8,070**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$5,000**

- **Specialist *[cost sharing]*** **$90**
- **Hospital (facility) *[cost sharing]*** ***40%***
- **Other *[cost sharing]*** ***40%***

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	$100
Copayments	$1,900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$5,000**

- **Specialist *[cost sharing]*** **$90**
- **Hospital (facility) *[cost sharing]*** ***40%***
- **Other *[cost sharing]*** ***40%***

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	$2,500
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Language Access Services:

ATTENTION: If you speak English, language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call 1-833-575-8033 (TTY 711).

Español (Spanish) ATENCIÓN: Si habla español, tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al 1-833-575-8033 (TTY 711).

አማርኛ (Amharic) ትኩረት፡ አማርኛ የሚናገሩ ከሆነ ተገቢ የሆኑ ረዳት መርጃዎችን እና አገልግሎቶችን ጨምሮ የቋንቋ እርዳታ አገልግሎቶች በነጻ ይገኛሉ። በ 1-833-575-8033 ይደውሉ (TTY 711)።

(Arabic) تنبيه: إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية بما في ذلك من وسائل المساعدة والخدمات المناسبة . العربية(TTY 711) 1-833-575-8033 بالمجان. اتصل بالرقم

中文 **(Chinese)** 注意事項：如果您說中文，您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 1-833-575-8033（TTY 711）。

(Farsi) از جمله کمکا ه و خدمات پشتیبانی مناسب، به ،« تسهیلات زبانی » ، توجه: اگر به زبان فارسی صحبت مین ک ید (فارسی تلفن متنی (TTY 711) .تماس بگیرید (TTY) 1-833-575-8033 صورت رایگان در دسترستان است اب

Français (French) ATTENTION: si vous parlez français, des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le 1-833-575-8033 (TTY 711).

Deutsch (German) ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen kostenfrei zur Verfügung. Rufen Sie 1-833-575-8033 an (TTY 711).

日本語 **(Japanese)** 注意：日本語を話す場合、適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。1-833-575-8033 までお電話ください（TTY 711）。

한국어 **(Korean)** 주의: 한국어를 구사하실 경우, 필요한 보조 기기 및 서비스가 포함된 언어 지원 서비스가 무료로 제공됩니다. 1-833-575-8033 로 전화해 주세요(TTY 711).

नेपाल (Nepali) ध्यान दनुहोस्: यद तपाइँ नेपाल बोल्नुहुन्छ भने, उपयुक्त सहायक सहायता र सेवाहरू सहत भाषा सहायता सेवाहरू, न:शुल्क उपलब्ध छन्। फोन 1-833-575-8033 (TTY 711).

Русский (Russian) ВНИМАНИЕ! Если вы говорите по-русски, вам доступны бесплатные услуги языковой поддержки, включая соответствующие вспомогательные средства и услуги. Позвоните по номеру 1-833-575-8033 (TTY 711).

Tagalog (Tagalog) PAALALA: Kung nagsasalita ka ng Tagalog, available sa iyo ang serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa 1-833-575-8033 (TTY 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói tiếng Việt, bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi 1-833-575-8033 (TTY 711).

Hindi: ध्यान द: य द आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-833-575-8033 (TTY 711)पर कॉल कर ।

Af-Soomaali (Somali): Fiiro gaar ah: Haddii aad ku hadasho Af-Soomaali, adeegyada kaalmada luqadda, oo bilaash ah, ayaa kuu diyaar ah. Wixii macluumaad dheeraad ah, fadlan wac 1-833-575-8033 (TTY 711).