Appendix A

Colorado Supplement to the Summary of Benefits and Coverage Form

INSURANCE COMPANY NAME	Access Connected Care Partners, Inc.
NAME OF PLAN	Colorado Access Choice EPO Bronze 7000 Rx Copay Off Exchange
1. Type of Policy	Individual Policy
2. Type of plan	Exclusive Provider Organization (EPO)
3. Areas of Colorado where plan is available.	Plan is available only in the following areas: Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Gilpin, Jefferson, Park, Pueblo and Teller.

SUPPLEMENTAL INFORMATION REGARDING BENEFITS

Important Note: The contents of this form are subject to the provisions of the policy, which contains all terms, covenants and conditions of coverage. It provides additional information meant to supplement the Summary of Benefits of Coverage you have received for this plan. This plan may exclude coverage for certain treatments, diagnoses, or services not specifically noted. Consult the actual policy to determine the exact terms and conditions of coverage.

	Description
4. Annual Deductible Type	EMBEDDED DEDUCTIBLE INDIVIDUAL - The amount that each member of the family must meet prior to claims being paid. Claims will not be paid for any other individual until their individual deductible or the family deductible has been met. FAMILY - The maximum amount that the family will pay for the year. The family deductible can be met by 2 or more individuals.
5. Out-of-Pocket Maximum	EMBEDDED OUT-OF-POCKET INDIVIDUAL - The amount that each member of the family must meet prior to claims being paid at 100%. Claims will not be paid at 100% for any other individual until their individual out-of-pocket or the family out-of-pocket has been met. FAMILY - The maximum amount that the family will pay for the year. The family out-of-pocket can be met by 2 or more individuals.
6. What is included in the In-Network Out-of-Pocket Maximum?	Deductibles, copayments and coinsurance. As specified in § 10-16-161, C.R.S., effective for all health benefit plans issued or renewed on or after January 1, 2025, all carriers shall include any amount paid by the covered person and/or by another person on behalf of the covered person for a prescription drug when calculating the covered person's overall contribution to an out-of-pocket maximum or cost-sharing requirement.

7. Is pediatric dental covered by this plan?	No, the plan does not include pediatric dental.
8. What cancer screenings are covered?	The following cancer screenings are covered as Preventive Services: breast cancer, cervical cancer, colorectal cancer and lung cancer. Plan also covers evidence based Preventive Care recommended by U.S. Preventive Services Task Force (UPSTF) A and B Recommendations.

USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
9. If the provider charges more for a covered service than the plan normally pays, does the enrollee have to pay the difference?	No	Yes
10. Does the plan have a binding arbitration clause?	No	

Questions: Call 1-833-575-8033 or visit us at www.coaccesschoice.com. If you are not satisfied with the resolution of your complaint or grievance, contact:

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Call: 303-894-7490 (in-state, toll-free: 800-930-3745)
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