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, call 1-800-475-8466 or go to www.cochoice.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.cciio.cms.gov or call your Benefits Department to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In Network **$500** individual / **$1,500** family. Out-of-network **$1,000** individual / **$3,000** 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**.
Are there services covered before you meet your deductible?	Yes. **Preventive care** is 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. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	For **network providers** $2,000 individual / $4,500 family; **for out-of-network providers** $7,000 individual / $15,000 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?	Cost containment penalties, **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.cochoice.com or call 1-800-475-8466 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 permission from this plan.

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		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 **copay**/office visit and **deductible** then 20% **coinsurance** for other outpatient services	40% **coinsurance**	None
	Specialist visit	$50 **copay**/office visit and **deductible** then 20% **coinsurance** for other outpatient services	40% **coinsurance**	None
	Preventive care/screening/ immunization	No charge	40% **coinsurance**	You may have to pay for services that aren't **preventive**. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	None
	Imaging (CT/PET scans, MRIs)	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	Preauthorization is required. If you don't get preauthorization, benefits could be reduced.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.OptumRx.com	Generic drugs	10% **coinsurance** (retail & mail order)	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Preauthorization may be required, penalties may apply.
	Preferred brand drugs	20% **coinsurance** (retail & mail order)	Not covered	
	Non-preferred brand drugs	30% **coinsurance** (retail & mail order)	Not covered	
	Specialty drugs	40% **coinsurance** to a maximum or $250 per prescription	Not covered	Only available through Briova – 30 day supply. Preauthorization required, penalties may apply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	**Preauthorization** required. If you don't get **preauthorization**, benefits could be reduced.
	Physician/surgeon fees	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	**Preauthorization** required. If you don't get **preauthorization**, benefits could be reduced.
If you need immediate medical attention	Emergency room care	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	None
	Urgent care	**Deductible**, then 20% **coinsurance**	**Deductible**, then 20% **coinsurance**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	**Deductible**, then 20% **coinsurance**	$250 **copay**, **deductible**, then 40% **coinsurance**	**Preauthorization** required. If you don't get **preauthorization**, benefits could be reduced.
	Physician/surgeon fees	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	**Preauthorization** required. If you don't get **preauthorization**, benefits could be reduced.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Deductible**, then 20% **coinsurance**	$250 **copay**, **deductible**, then 40% **coinsurance**	None
	Inpatient services	**Deductible**, then 20% **coinsurance**	$250 **copay**, **deductible**, then 40% **coinsurance**	**Preauthorization** required. If you don't get **preauthorization**, benefits could be reduced.
If you are pregnant	Office visits	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	**Cost sharing** does not apply to certain **preventive services**. Depending on the type of services, **coinsurance** may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	
	Childbirth/delivery facility services	**Deductible**, then 20% **coinsurance**	$250 **copay**, **deductible**, then 40% **coinsurance**	
If you need help recovering or have other special health needs	Home health care	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	Ten (10) visits calendar year maximum. Preauthorization required for visits over 10.
	Rehabilitation services	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	60 visits combined annual maximum for Physical, Speech & Occupational Therapy
	Habilitation services	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	60 visits combined annual maximum for Physical, Speech & Occupational Therapy
	Skilled nursing care	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	Within 7 days of a 3 day stay; 60 day calendar year maximum
	Durable medical equipment	**Deductible**, then 20% **coinsurance**	**Deductible**, then 40% **coinsurance**	Preauthorization required for equipment over $500.00
	Hospice services	**Deductible**, then 20% **coinsurance**	**Deductible**, then 20% **coinsurance**	180 day inpatient and outpatient lifetime maximum
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	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
- Dental Care (Adult)
- Hearing Aids (Adult)
- Long Term Care
- Non-emergency care when traveling outside U.S.
- Routine Eye Care (Adult)
- Routine Hearing Exams (Adult)
- Routine Foot Care
- Weight Loss Programs

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

- Acupuncture
- Bariatric surgery
- Hearing aids (up to age 18)
- Private Duty Nursing
- Chiropractic Care
- Infertility Treatment

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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 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: Colorado Choice Health Plans at 1-800-475-8466.

For group health coverage subject to ERISA, you can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the Colorado Department of Insurance at 303-894-7490 or www.dora.state.co.us/insurance.

Does this plan provide Minimum Essential Coverage? **YES**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? **YES**

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-475-8466.

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

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	$500
Specialist Copay	$50
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$420
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$500
Specialist *Copay*	$50
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$340
Coinsurance	$780
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,675**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$500
Specialist *Copay*	$50
Hospital (facility) *Coinsurance*	20%
Other *Coinsurance*	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$150
Coinsurance	$210
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$860**

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