This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.cochoice.com** or by calling **1-800-475-8466**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$3,500 Individual / $7,000 Family In-Network	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan documents to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $6,350 Individual / $12,700 Family In-Network	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums and health care costs not covered by this plan.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit.**
Is there an overall annual limit on what the plan pays?	No.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits.
Does this plan use a network of providers?	Yes. See **www.cochoice.com** or call **1-800-475-8466** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Not needed for an in-network specialist consult. Procedures or other services may need a referral.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

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- **Copayments** are fixed dollar amounts (for example $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury/illness	$25 copay / visit	Not Covered	Not subject to deductible
	Specialist visit	$50 copay / visit	Not Covered	Not subject to deductible
	Other practitioner office visit	$50 copay / visit	Not Covered	Not subject to deductible
	Preventive care / screening / immunization	$0 copay / visit	Not Covered	Deductible does not apply.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	
	Imaging (CT / PET scans, MRIs)	30% coinsurance	Not Covered	

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.cochoice.com.	Generic drugs	$15 copay	Not Covered	Not Subject to Deductible
	Preferred brand drugs	$40 copay	Not Covered	Not Subject to Deductible
	Non-preferred brand drugs	$60 copay	Not Covered	Not Subject to Deductible
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	
	Physician / surgeon fees	30% coinsurance	Not Covered	

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$300 copay	$300 copay	Not Subject to Deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	No coinsurance - ground; 15% coinsurance - air
	Urgent care	$60 copay	$60 copay	Not Subject to Deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	
	Physician / surgeon fee	30% coinsurance	Not Covered	

Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay / visit	Not Covered	Not Subject to Deductible
	Mental/Behavioral health inpatient services	30% coinsurance	Not Covered	
	Substance use disorder outpatient services	$25 copay / visit	Not Covered	Not Subject to Deductible
	Substance use disorder inpatient services	30% coinsurance	Not Covered	
If you are pregnant	Prenatal and postnatal care	$25 copay / visit	Not Covered	Not Subject to Deductible
	Delivery and all inpatient services	30% coinsurance	Not Covered	

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Common Medical Event	Services You May Need	Your Cost if You Use an In-network Provider	Your Cost if You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	
	Rehabilitation services	$30 copay / visit	Not Covered	Copays apply after deductible has been met
	Habilitation services	$30 copay / visit	Not Covered	Copays apply after deductible has been met
	Skilled nursing care	30% coinsurance	Not Covered	
	Durable medical equipment	30% coinsurance	Not Covered	
	Hospice service	30% coinsurance	Not Covered	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services and Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids (Adult)
- Infertility Treatment
- Long-Term Care
- Non-Emergency Care (outside US)
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- Weight Loss Programs
- -
- -

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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If you aren't clear about any of the underlined terms used in this form, see the glossary. You can view the Glossary at **www.cochoice.com** or call **1-800-475-8466** to request a copy.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at **1-800-475-8466**. You may also contact your state insurance department, the 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can 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.

Language Access Services:

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $3,290**
- **Patient pays $4,250**

Sample care costs:

Hospital charges (mother)	$	2,700
Routine obstetric care	$	2,100
Hospital charges (baby)	$	900
Anesthesia	$	900
Laboratory tests	$	500
Prescriptions	$	200
Radiology	$	200
Vaccines, other preventive	$	40
Total	**$**	**7,540**

Patient pays:

Deductibles	$	2,790
Copays	$	20
Coinsurance	$	1,340
Limits or exclusions	$	100
Total	**$**	**4,250**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers: $5,400**
- **Plan pays $3,570**
- **Patient pays $1,830**

Sample care costs:

Prescriptions	$	2,900
Medical Equipment & Supplie	$	1,300
Office Visits & Procedures	$	700
Education	$	300
Laboratory tests	$	100
Vaccines, other preventive	$	100
Total	**$**	**5,400**

Patient pays:

Deductibles	$	1,150
Copays	$	600
Coinsurance	$	-
Limits or exclusions	$	80
Total	**$**	**1,830**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your help plan allows.

Can I use Coverage Examples to compare plans?

✗ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✗ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.